An exploration of factors contributing to ethnic disparities in compulsory detention with a focus on Black women's experiences.

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

In the UK, there are ethnic disparities in the rate of compulsory detention, with Black people being more likely than White British people to be detained against their will. Part I of this thesis explores the reasons underlying the disparities and proposes a new model to explain the underlying causes. The new model considers the contexts in which the Black person being assessed under the mental health act and the healthcare professionals conducting the assessment are situated. It also outlines mechanisms and inter- and intra-personal processes that interact to influence how both parties behave and make decisions during the sectioning process. Part II of the thesis is comprised of an empirical paper exploring four Black women's experiences of the decision being made for them to be compulsorily detained and the factors that they believe influenced that decision. Interpretative phenomenological analysis (IPA) was used to explore how the women made sense of their experiences. Results demonstrated that the women found the experience of being detained to be distressing and that meaningful relationships helped them to manage. Where care provision did not feel sufficient, they acknowledged the under-resourced nature of the healthcare system. The women believed that their behaviour and mental health needs were primary reasons for the decision being made to compulsorily detain them. Part III of the thesis provides a critical appraisal of the research process, with a particular focus on how the researcher's identity influenced and interacted with the research topic.

Impact statement

The research provided in this thesis has benefits both inside and outside of academia. The model presented in Part I of the thesis outlines new ways of conceptualising the ethnic disparities in compulsory detention. It encompasses factors and processes spanning a broad range of areas, illustrating how the entire system in which a person is embedded can contribute to inequalities in psychiatric treatment. The bringing together of various contributing factors in this way allows for a new understanding of the problem, and therefore new solutions to be explored in future. Furthermore, the research study in Part II adds further weight to this by providing a platform for Black women’s voices to be heard. Being at both the intersection of race and gender, Black women are often underrepresented within research and service development. From this research project, their experiences and perspectives can be used to inform the way in which healthcare services respond to people’s needs during involuntary admission.

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Part I: Literature review

Ethnic disparities in compulsory detention: A proposed contextual model

Abstract

Despite longstanding observations that Black people are significantly more likely to be compulsorily detained than White British people, government initiatives have not been able to reduce the inequality. This may be because there has been limited understanding of the mechanisms underlying the disparities and therefore past solutions have not been able to identify effective targets to establish progress. This conceptual literature review aimed to provide a rich understanding of the factors underlying the ethnic disparities by proposing a new explanatory model. The contextual model of ethnic disparities in compulsory detention uses a formulative approach to facilitate a better understanding of the factors and processes that influence behaviour during the decision-making process involved in sectioning. The model considers the factors that influence the perspectives and behaviours of the Black person being detained and of healthcare professionals during the mental health act assessment where the decision to compulsorily detain a person is made. It also highlights the dynamic interaction between the Black person being assessed and the healthcare professionals conducting the assessment. Finally, it proposes mechanisms that may determine whether the contextual factors influence the likelihood of being compulsorily detained. Implications for clinical practice, policymakers and suggestions for further research are proposed.

Ethnic disparities in compulsory detention

In the UK, the number of people detained in hospital under the Mental Health Act (1983) has steadily increased over time, with 29,593 detentions being recorded in 1990/1991 compared to 63,622 detentions in 2015/2016, a 40% increase on the number of detentions recorded in 2005/2006 (Care Quality Commission, 2018). Within these increasing rates of detention, ethnic inequalities are consistently observed. Black people are significantly more likely to be compulsorily detained than their White British counterparts (Barnett et al., 2019; Weich et al., 2017). During 2018-2019 in England, Black people were four times more likely to be detained under the mental health act and more than eight times more likely to be placed on a community treatment order than their White British counterparts (NHS Digital, 2019). Ethnic disparities remain when local service and trust level factors, such as socioeconomic deprivation, bed capacity and service performance, are also accounted for within a multifactorial model (Weich et al., 2017).

Pathways into services also differ across ethnicities, with Black patients being significantly more likely than White and Asian patients to have had at least one contact with the criminal justice system (Singh et al., 2015). Black patients are more than twice as likely to have criminal justice involvement (OR 2.49, 95% CI 2.06 to 3.00, $n = 17$) and almost three times as likely to have police contact (OR 2.96, 95% CI 2.10 to 4.17, n = 10) during their pathway to mental health services (Halvorsrud et al., 2018). These ethnic disparities have been linked to Black patients being less likely to have GP involvement in their pathway to care (Ghali et al., 2013; Halvorsrud et al., 2018), suggesting that they are more likely to present to services at the point of crisis where involuntary hospitalisation is more likely to be deemed essential.

The need for insight into mechanisms underlying the ethnic disparities

The ethnic disparities in rates of compulsory detention are of major concern to patients, healthcare providers and policy makers (Oduola, Craig, et al., 2019). Patients describe that being detained against one’s will can be a frightening and distressing experience (Akther et al., 2019) that feels violating and humiliating (Lu et al., 2017) and impacts negatively on self-worth (Akther et al., 2019), regardless of whether it is beneficial in the long-term.

Some patients who have experienced negative events in hospital proceed to develop hospital-related post-traumatic stress disorder (PTSD) symptoms that are connected to the most distressing aspects of their time as an inpatient (Abdelghaffar et al., 2018; Berry et al., 2013; Berry et al., 2015; Fornells-Ambrojo et al., 2016). The most commonly identified events associated with hospital-related PTSD symptoms include being put into seclusion, being restrained, being admitted to hospital, being physically assaulted by a fellow patient, and being forced to take medication (Abdelghaffar et al., 2018; Berry et al., 2015). Black people are significantly more likely to be subjected to seclusion and physical restraint than White patients; 56.2 per 100,000 population for Black Caribbean as against 16.2 per 100,000 population for White patients (Mind, 2019).

PTSD symptoms are twice as prevalent in people in restricted inpatient settings than their counterparts in unrestricted settings (Rodrigues & Anderson, 2017). People who experience both psychosis and PTSD are likely to have more severe and chronic symptoms, poorer life satisfaction and greater use of services (Buckley et al., 2008), but lower engagement and satisfaction with mental health services (Alang & McAlpine, 2018; Minsky et al., 2015; Weich et al., 2017). With people from Black communities being more likely than people of White ethnicity to experience compulsory hospitalisation as negative (Katsakou et al., 2012) they may be at a greater risk of developing hospital-related PTSD.

Adverse, coercive treatment has also been consistently associated with poorer long-term outcomes (Anderson et al., 2010; Fearon et al., 2006; Morgan et al., 2005), which can increase the risk of further coercion (Rodrigues et al., 2019). Patients who have been admitted to hospital are at risk of harm from institutionalisation, potential harm from staff or other patients and the loss of housing and employment (Bowers et al., 2009; Lloyd-Evans & Johnson, 2019).

Given the potential negative outcomes of involuntary hospitalisation, there is an ethical and moral responsibility for efforts to be made to reduce the ethnic disparities in the use of the mental health act powers. Despite its most recent update in 2007, the Mental Health Act (1983) in its current form and application is not in accordance with human rights laws (Department of Health and Social Care, 2019b). Action is required to address the healthcare inequalities faced by specific minoritised ethnic groups, and given the extensive data available, in particular for Black African, Black Caribbean and Black British/Other communities (Schizophrenia Commission, 2012). Understanding the mechanisms underlying the ethnic disparities is a matter of priority for researchers and policymakers (Walker et al., 2019), and is essential for progression beyond the enumeration of the inequalities to produce recommendations for future policies and service reform (Morgan et al., 2004).

Ethnic disparities in compulsory detention: a proposed contextual model

Rationale for a new model

Ethnic disparities in rates of compulsory detention have been extensively reported and numerous policy initiatives have been conducted, such as the Inside

Out report (National Institute for Mental Health in England, 2003), the Delivering Race Equality (DRE) Action Plan (Department of Health, 2005) and the Joint Commissioning Panel for Mental Health (2014) recommendations. However, ethnic disparities in compulsory detention rates have remained relatively unchanged.

While the DRE Action Plan successfully raised awareness of race inequalities in mental health care, it was unable to reduce admission, detention and seclusion rates of people from Black communities (Care Quality Commission, 2011), which continued to disproportionally increase over duration of the programme. In its five year review, the DRE concluded that there was a greater need for better quality research into the ethnic disparities, recognising the importance of exploring the issues faced by individual BME groups distinctly from each other (National Mental Health Development Unit, 2009; Wilson, 2010). The Joint Commissioning Panel for Mental Health (2014) guidance describing what ‘good’ mental health services for Black and Minority Ethnic communities look like was derived from the learnings of the DRE programme, however application of the guidance has not become embedded into mainstream services, and many smaller-scale local projects terminated or became side-tracked from their focus on race (Department of Health and Social Care, 2019a).

The DRE Action Plan was an extensive and well-intentioned initiative that involved ‘BAME’ communities, experts by experience, and commissioners. Using a research-driven approach, the team attempted to implement changes with accountability and increase awareness of the problems faced by minoritised ethnic communities. However, despite their research finding that the people’s needs varied across ethnic groups, there were very few interventions designed to specifically target outcomes for Black people.

Crucially, although a broad spectrum of interventions were carried out over the five-year period, hypothesised mechanisms of change underlying each intervention were not clearly described. There was no clear rationale outlining how interventions should reduce the disproportionate rate of compulsory detention of Black people, even though this was a core drive for the initial report. It appears that most interventions aimed to increase engagement of ‘BAME’ services users and acceptability of psychological therapy, but this was not grounded on a formulation capturing the complexity of factors involved in the disproportionate compulsory admission rates amongst Black people.

Being a research driven approach, the DRE Action Plan team may have found it challenging to focus on the mechanisms underlying ethnic disparities because literature in this area provides very limited explanation. A recent systematic review and meta-analysis of 71 studies exploring rates of the use of involuntary detention in ethnic minority communities reported that 48% of studies provided either no explanation or untested explanations for the ethnic disparities in risk of compulsory detention (Barnett et al., 2019). Of those that did, ‘explanations’ proposed tended to state *what* disparities exist as opposed to hypothesising *why* the disparities exist. Barnett et al. (2019) observed the most frequent explanations to include increased prevalence of psychosis, increased perceived risk of violence and increased police contact without explaining why such increases are present. In particular, studies have tended to include limited information on socioeconomic, cultural or structural factors contributing to detention rates. The lack of empirical insight and recommended actions are a fundamental barrier to developing effective policies to prevent and reduce disparities in detention rates.

In response to this gap in understanding, the model proposed in this chapter adopts a sociocultural perspective to understand the mechanisms underlying ethnic disparities in compulsory detention. The model draws attention to the importance of targeting relatively ignored contextual factors and processes in order to achieve a measurable reduction in the proportion of Black people being compulsorily detained.

Introduction to the model and its aims

The contextual model of ethnic disparities in compulsory detention uses a formulative approach to facilitate a better understanding of the factors and processes that influence behaviour during the decision-making process involved in sectioning. The model considers the perspective of the Black person being detained, outlining the contextual factors that influence their experience of mental health symptoms, their expression of distress and their behaviour during the time of sectioning (and events leading up to it). It also considers the contextual factors that influence the experience of healthcare professionals during the mental health act assessment period where the decision to compulsory detain a person is made. The model then highlights the interaction between the Black person being assessed and the healthcare professionals conducting the assessment. The processes are not considered to be mutually exclusive. Instead the model proposes that they are enacted simultaneously and influence each other.

The model is novel in that it specifically highlights the roles of a range of factors that may contribute to the decision being made to compulsorily detain a Black person. The model could be flexible enough to be applied idiosyncratically, with each factor and process being likely to vary from person to person. Analysis of decision-making from this framework could facilitate further reflection on how and why decisions are being made. It could also be useful for reducing the extent of bias involved by drawing attention to the factors that might be influences perception, behaviours and choices. Furthermore, each of the factors identified in the model could act as a target for interventions aimed at reducing the disparities, although because of their varying contributions to each individual person's case, multiple factors may have to be addressed simultaneously to observe an effect.

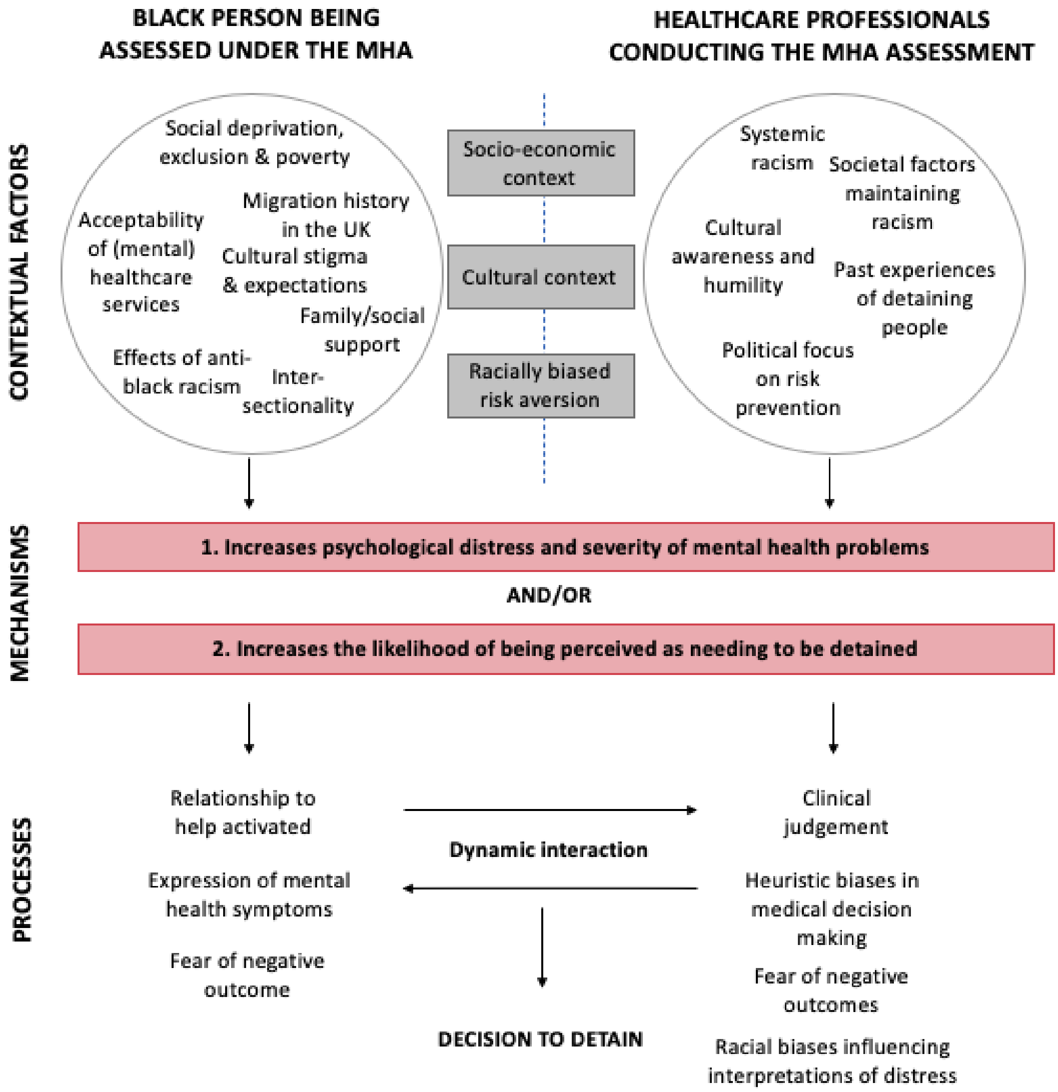

Figure 1: Proposed model of contextual factors, mechanisms and processes that influence the decision to compulsorily detain a Black person

Contextual factors, mechanisms and processes that influence experience and behaviour during the mental health act assessment process

The model summarises a range of factors that influence how the Black person being assessed and the healthcare professionals conducting the assessment could experience and behave. Three broad themes are suggested to encompass all of the contextual factors: (i) socioeconomic deprivation, exclusion and poverty, (ii) cultural expectations of mental health, service provision and help-seeking, and (iii) racially biased risk-aversion and decision-making. These contextual factors may influence the likelihood of being compulsorily detained via two mechanisms, (1) increasing the severity of mental health problems and thus the need for compulsory detention and (2) increasing the likelihood that healthcare professionals will perceive the Black person being assessed as needing to be detained.

The analysis below outlines how each of the themes relates to the mechanisms identified to influence the decision being made to compulsorily detain a person.

Socioeconomic deprivation, exclusion and poverty

In the UK, people from minoritised ethnic groups are disproportionally impacted by deprivation, social exclusion and poverty, with Black people being amongst the most affected (Vernon, 2020). Black people are more likely to be living in poverty due to being employed in lower paid work (Henehan & Rose, 2018), having higher rates of part-time working and unemployment (Office for National Statistics, 2016), and relatively low levels of overall income (Khan, 2020). For every £1 of White British wealth, Black Caribbean people have around 20p and Black African 10p (Khan 2020). Changes to fiscal policies which reduce income from benefits and make cuts to public services affect people from minoritised ethnic groups the most, exacerbating racial inequalities in the economy (Khan, 2015; Women's Budget Group, 2017). This is important to hold in mind because socioeconomic factors such as higher levels of neighbourhood income inequality, absolute deprivation and population density are associated with an increased severity of psychological distress, risk of psychosis (Kirkbride et al., 2014) and rates of compulsory detention (Bindman et al., 2002)

The association between socioeconomic factors and rates of compulsory detention may arise because social deprivation, exclusion and poverty places unfair limits on access to resources and opportunities, resulting in adverse experiences such as housing instability, exposure to violence, proximity to crime, unemployment, and environmental neglect (Shim & Compton, 2020). These are significant drivers of psychosocial stress that, by virtue of the insecurity they cause, negatively impact on psychological wellbeing while limiting the degree to which a person can actively contribute to and be involved in society (Kingsford & Webber, 2010). This could contribute to increasing the severity of mental health symptoms and thus the likelihood that compulsory detention is needed. Furthermore, having complex social needs such as poor quality housing, financial instability and exposure to violence may impact the healthcare professionals' perception of risk; they may be more likely to determine that it is an unsafe environment for an individual to be left in and therefore be more likely to deem compulsory detention as essential (Sundquist & Ahlen, 2006).

One of the reasons why Black people are more likely to experience social deprivation is their migration history into the country. The journey differed for Black Caribbean and Black African people which may contribute to the intragroup nuances observed in both extent of social deprivation and in the ethnic disparities in sectioning. Black Caribbean people settled in the UK post-World War II, entering the country as British citizens of the Commonwealth (McDowell, 2018), whereas people of Black African heritage has been steadily increasing since the more recent second wave of migration that began in the late 1980s. As a result of this, Black Caribbean families are likely to have been settled in the UK for two or more generations than people of Black African backgrounds, therefore may be more acculturated into British culture with a more established social network, and have had greater opportunities to accrue wealth (Bhugra, 2005; Khan, 2020; Oduola, Craig, et al., 2019; Oduola, Das-Munshi, et al., 2019). As the absence of these social relationships is known to be associated with increased psychological distress (Boydell et al., 2013; Morgan et al., 2009), being well-established in the UK may have been an increasing protective factor for Caribbean people over time. This may be relevant for explaining why rates of detention for Black Caribbean people have decreased over the last 15 years, while rates of detention for Black African people have remained about the same (Oduola, Craig, et al., 2019).

Social deprivation is also associated with a longer duration of untreated psychosis (DUP), with people living in more deprived neighbourhoods facing up to a 36 day longer DUP than people in the least deprived areas of England (Reichert & Jacobs, 2018). While there are likely a number of contributing factors, the relationship between social deprivation and DUP is thought to be largely focused around employment status; Morgan et al. (2006) observed that the median DUP for people who were unemployed was 13 weeks compared to 5 weeks for those employed or in higher education. This might be because being unemployed reduces the visibility of the disruption caused by symptoms of psychosis (Morgan et al., 2006), minimising the likelihood of the individual experiencing symptoms to seek help or for others to seek help on their behalf. A longer DUP might also result in increased unemployment due to reduced social functioning and increased social withdrawal (Morgan et al., 2006). A longer DUP is associated with increased likelihood of compulsory detention, as a result of a more severe worsening of symptoms, resulting in an acute crisis.

The relationship between social deprivation and longer DUP is also thought to be related to an absence of family involvement in help-seeking (Morgan et al., 2006). The role of family support in accessing mental health services might be particularly relevant for the analysis of Black people's experience of psychosis because of cultural expectations of mental health and mental healthcare provision.

Cultural expectations of mental health, service provision and help-seeking

A person's understanding of the world and their experiences within it is shaped by factors such as their culture and personal life experiences. In the context of mental health, cultural beliefs can influence explanatory models of illness and how people make sense of unusual experiences such as hallucination and delusions, being given a diagnosis such as psychosis or schizophrenia, and expressions of psychological distress (Singh et al., 2015). These beliefs can also inform help-seeking preferences. In the UK, unlike people of Asian heritage who are more likely to have different models of mental illness, Black people are as likely as White people to adopt a neutral stance of giving no specific attribution of causation of illness symptoms (Singh et al., 2015). However, help-seeking behaviour does differ, with Black people being more likely than White people have consulted faith-based practitioners during their care pathways or alongside health service provision (Singh et al., 2015). It is possible that this could affect the likelihood of being compulsorily detained by delaying help-seeking, which could lead to a worsening of mental health problems. Furthermore, preferences for a faith-based intervention could contribute to Black people declining the care available from mental health services, contributing to clinicians' beliefs that compulsory detention is essential.

Black people may avoid healthcare services as a result of justifiable fear about potential negative outcomes. Medicine and psychiatry have a history of mistreating Black people through coercion and unethical practice, many examples of which are known throughout the Black community. Medical theories such as having thicker skin and a less sensitive nervous system were used to justify the maltreatment of enslaved Africans (Gamble, 1993), experimental gynaecological surgical procedures were carried out on enslaved women without anaesthesia (Sartin, 2004) and, within the last century, medical research has been carried out Black people with their full informed consent, for example the cases of Henrietta Lacks (John Hopkins Medicine, n.d.) and the Tuskegee Syphilis Study (Gamble, 1993). These racist roots have left a legacy of distrust in the Black community; history has taught Black people that the principle of 'first, do no harm' does not apply to them. Recent reports of Black people being more than four times more likely to die from coronavirus (Office for National Statistics, 2020) and Black women more than five times more likely to die during childbirth than White people (Knight et al., 2019) provides further evidence that the Black people's lives are still less valued by the UK healthcare system.

Understandably, healthcare systems can be fear-provoking for Black people, particularly where coercive treatment is a possibility. Codjoe et al. (2019) reported a Black focus group participant stating, "they will lock you up and when they lock you up that’s it” (p. 226). Black people are more likely to come into contact with mental health services through the criminal justice system (Ghali et al., 2013), with whom relationships are already extremely strained (Sharp & Atherton, 2007). The association between the criminal justice system and mental health services may not be helpful for building trust in healthcare provision. Furthermore, being involved in the criminal justice system may lead healthcare professionals to be more likely to perceive an individual as having a greater level of risk based on their background notes. Black people are also more likely to have longer periods of admission and compulsory re-admission (Ajnakina et al., 2017), reinforcing the ‘once you’re in, you’re in’ belief about psychiatric healthcare. The fears that Black people have about the mental health system are not unfounded but based on real historical abuses of power and longstanding inequalities in healthcare treatment which still persist today.

The fear and mistrust of the system may contribute to understanding why Black people are less likely to have visited the GP in their care pathway (Memon et al., 2016). When they seek support from the GP, Black people are less likely to offered treatment or be referred to specialist services (Memon et al., 2016) which may lead Black people to feel as though their concerns are not be listened to, understood or taking seriously and discourage them from seeking further support. It may also reinforce any existing beliefs that the difficulties that they are experiencing can and should be managed using their own coping strategies, for example seeking faith-based support. Both of these situations could lead to more severe mental health problems developing in the long-term that could require involuntary hospitalisation. In addition to being apprehensive about being admitted to hospital, the lack of urgency communicated by GP contact may lead Black people to be less likely to agree to be admitted to hospital on a voluntary basis as they may not perceive it as being essential. This could be understood by healthcare professionals as them having less insight and therefore increase the degree to which the healthcare professionals believe the Black person requires a hospital admission.

In addition to fear and mistrust of healthcare services, as with wider society, stigma about mental health is present within the Black community. Black people have fewer negative appraisals of psychotic illness than people from White and Asian ethnic groups, and no ethnic disparities are observed in shame associated with having experiences of psychosis (Upthegrove et al., 2013). However, the nuances of stigma appear to be complex and the differences between Black communities and subcultures are important to consider here. In a series of focus groups, Black African people with experience of becoming unwell highlighted that mental health stigma in their community negatively impacted their wellbeing and increased psychological distress. This differed from Black Caribbean participants who placed greater significance on the presence of racial inequalities in the mental health treatment (Shefer et al., 2013) .

Stigma is important when considering the ethnic disparities in compulsory detention because it has implications for how much social support and family involvement an individual might have. Mental health stigma is associated with increased desire for social distance, as measured by the Reported and Intended Behaviour Scale (RIBS) scale (Codjoe et al., 2019). This can impact not only the Black person experiencing the mental health problem but also their family by extension. As a result, friends, family and community social support may withdraw should an individual choose to engage with mental health services (Corrigan et al., 2017).

Lower levels of social support are associated with a compulsory detention (Webber & Huxley, 2004). A strong social network can be helpful in maintaining engagement with healthcare services, offer practical and emotional support, and can notice and report signs of worsening mental health to professionals services before a person's mental state becomes severe enough for inpatient admission. A lack of social support has been consistently identified as a risk factor for the psychosis, with social isolation and loneliness being strongly associated with psychosis, severity of positive symptoms, and low mood (Sündermann et al., 2014). People who have experienced symptoms of psychosis have described that a lack of social support and sense of community has a detrimental effect on the experience of psychosis (Schofield et al., 2019).

Furthermore, mental health stigma could have implications for the way in which Black people respond to healthcare professionals during the mental health act assessment process. If stigmatised beliefs become activated, the person being assessed may respond in a more hostile, dismissive and rejecting manner or disengage from the assessment process completely. This presentation may impact the way in which healthcare professionals make decisions about the care that is needed and may be more likely to judge that compulsorily detention is essential for the person to appropriately engage in treatment. Furthermore, any hostility that the Black person displays could be perceived as threatening to the healthcare professionals conducting the assessment, which may influence their assessments of risk.

Racially biased risk-aversion and decision-making

Mental health services in the UK are embedded in a highly risk-averse culture; this is also the environment in which compulsory powers outlined in the

Mental Health Act are used. The Mental Health Act presents society and state with a socio-political paradox. It serves to help those who would benefit from treatment for their mental health illness, with an intention to also protect the patient and the public from risk of harm, however it is a monumental imposition on freedom and liberty, which can be a distressing and traumatic experience for those of on who it is used and for their friends and family members.

The aims of the Mental Health Act remain to be a contentious issue; it is unclear whether it is needed to protect those who lack capacity, to protect the public from risk of harm by people experiencing mental health crises, or to reduce the anxieties of risk-averse mental health professionals (Szmukler & Holloway, 2000). By deduction, the disproportionate use of the Mental Health Act to compulsorily detain Black people indicates that (i) a greater proportion of people who lack capacity are Black and/or (ii) Black people are (perceived as being) more dangerous than White people. As discussed above, there are various reasons why Black may have more severe symptoms of psychosis or be perceived as not having capacity (e.g. by disengaging or declining voluntary treatment), however Black people in the UK are also perceived as being a greater risk of harm to others.

The Angiolini Report argues that the racist trope of Black people as ‘dangerous, violent and volatile’ influences how Black people are perceived, particularly Black men (Angiolini, 2017). When Black people have a mental illness, this increases the level of threat that they are perceived to pose by adding the assumption that they are also unpredictable and irrational. These racist tropes and stereotypes lead to the dehumanisation of Black people, reducing the amount of compassion and empathy they are shown regardless of the fact that when experiencing mental health problems, they are too vulnerable, unwell and in need of care (Walker, 2020).

The notion of ‘Big, Black and Dangerous’ is not new (Prins et al., 1993); it arose from the cases of Michael Martin in 1984, Joseph Watts in 1988, and Orville Blackwood in 1991, three Black men diagnosed with schizophrenia who were killed by physical and chemical restraint while detained in Broadmoor Hospital. These cases were not unique to that hospital or period of time; David ‘Rocky’ Bennet died in 1998 after being restrained while detained in a secure psychiatric unit and more recently, Sean Rigg died in 2008 after being restrained by police while experiencing a mental health crisis. The theme across all of these cases is the harmful and unjust use of force to manage their behaviour while in a state of distress, possibly due the racist misinterpretation of how much of a threat these Black men pose.

The perception of Black people as being a greater threat, simply because they are Black, could increase the likelihood the healthcare professionals would deem compulsory detention as essential to reduce the risk of harm to others. Empirical data support this; Black people are significantly more likely to be admitted as a result of being involved in a violent incident and/or being perceived as threatening by others (Morgan et al., 2005), or perceived as being at higher risk of ‘violent acting out’ (Singh et al., 1998). White women are significantly more likely to be detained for being at risk of harming themselves as opposed to others (Lawlor et al., 2010). Racial biases held by healthcare professionals may influence their decision making in these circumstances.

There is an assumption that healthcare professionals are somewhat immune from the effects of bias when making clinical decisions because they have chosen to work in a caring profession where gold standard care would be neutral and entirely equal. However, this is a fallacy; healthcare professionals are also exposed to the social narratives about negatively racialised and minoritised groups of people, so they are just as likely as other people to implicitly endorse commonly held unhelpful and discriminative beliefs (FitzGerald & Hurst, 2017). These biases have the power to influence clinical decision making, particularly during times of high pressure where risk averse responses are more likely to be elicited (Jefferies-Sewell et al., 2015). This is particularly concerning when they influence the way in which healthcare professionals respond to people who are already vulnerable (FitzGerald & Hurst, 2017).

Evidence suggests that racial biases affect clinical judgement and behaviour. Black people rated interactions with healthcare professionals who have higher levels of implicit bias against Black people as being more negative (Blair et al., 2013; Cooper et al., 2012; Penner et al., 2010). Pro-White implicit bias is significantly correlated with preferable treatment decisions for White service-users (Green et al., 2007; Peris et al., 2008; Sabin & Greenwald, 2012; Sabin et al., 2008). Furthermore, the influence of implicit biases was demonstrated in a study where a vignette of a person presenting for inpatient admission was followed by information about risk provided as either numerical or percentage probability and using the semantic labels “high” and “low” risk, despite the actual risk being the same across the four conditions. When risk information was presented numerically and labelled as “high”, clinicians were more likely to opt to admit the person in the vignette. This indicates that if more risk-associated language is used to describe the presentation of Black people experiencing mental health problems, which may happen because Black people are perceived to be more threatening, healthcare professionals could be more primed to make the decisions to compulsorily detain them (Jefferies-Sewell et al., 2015).

Implicit biases are more likely to influence choices in ambiguous and uncertain situations because of the pressure to make accurate decisions. The pressure to make accurate decisions is high for healthcare professionals conducting mental health act assessments, who have reported that the decision-making process can be fear-provoking; clinicians fear that they may be at risk of harm themselves, they fear that choosing not to detain someone could result in a harmful outcome for the person while also acknowledging that if they do detain them it could also have harmful outcomes, and they fear the negative personal and professional consequences that could arise from any harm caused as a result of their decision (Allen & McCusker, 2020). The risk feels high for professionals who are embedded in a risk averse system and tasked to make fair clinical judgments about the wellbeing of Black people who may themselves be perceived as risky by virtue of their race.

Racial biases in the assessment process could also impact the experience of the person being assessed; suspecting the presence of racial biases could activate previous experiences of racism and influence their behaviour towards healthcare professionals and engagement in the assessment process (van Ryn et al., 2011). Experiencing the healthcare professionals as holding racist attitudes or displaying microaggressions might activate stereotype threat, which can generate feelings of anger, frustration, fear and may increase levels of withdrawal, hostility and defensiveness in an effort to protect oneself (Comas-Díaz, 2016). If a person has past experiences of racism, they may be particularly attuned to detecting racist attitudes and be sensitised to its effect, which can result in a response that could appear disproportional to the racist action (Sue et al., 2007). Furthermore, the effects of racism in interactions can be particularly impactful for people who hold multiple oppressed identities simultaneously, for example Black women (Crenshaw, 2017). Resistant responses from the Black person being assessed might negatively reinforce the racial biases held by healthcare professionals, with the interaction becoming a self-fulfilling prophecy (van Ryn et al., 2011). This might increase the degree to which healthcare professionals are biased towards decision that the person should be compulsorily detained.

Summary of the model

The proposed model attempts to provide a more complex analysis than is currently available to explain why Black people are significantly more likely to be compulsorily detained than White people. It conceptualises the ethnic disparities in compulsory detention as resulting from two mechanisms, (1) increased severity of mental health problems in Black people meaning that they require more urgent care and (2) and increased likelihood of healthcare professionals perceiving the Black person being assessed as needing to be detained. It posits that contextual factors influence the experiences and behaviours of Black people being assessed and the healthcare professionals conducting the assessment, which interact with each other and feed into increasing the mechanism stated above. It also proposes that during the assessment and at the time of sectioning, processes play out in real-time that influence the way in which the Black person being assessed and the healthcare professionals conducting the assessment interact with each other, influencing the decision to detain.

There have been multiple initiatives run in previous years that have attempted to address the ethnic disparities in sectioning with little effect. They often focused on higher level interventions such as increasing ‘BAME’ engagement in services and using a one-size-fits-all approach to meeting the needs of ‘BAME’ services users. However, for there to be significant improvement, interventions need to have a richer understanding of the problem by asking more questions during the design phase and tailoring approaches to address the nuances in the complexities of the underlying issues. The factors proposed in the model are not mutually exclusive; they interact with each other to varying degrees in different individuals therefore multifaceted solutions are required which target the various root causes simultaneously.

Targeting relevant factors might be achieved by focusing on each of the two mechanisms involved. Table 1 on page 46 summarises the overarching themes discussed above and the mechanisms that they influence in the proposed model. It is clear from the table that solutions addressing the (mis)perceptions of mental health professionals are just as relevant as factors that reduce the severity of mental health symptoms.

Solutions focused on reducing the severity of mental health symptoms may focus on addressing the socioeconomic circumstances in which Black people are disproportionately embedded in. This might include improving housing provision, increasing financial security, improving access to employment, and promoting a more fair and equal anti-racist society. From this perspective, the ethnic disparities are positioned as a public health crisis which requires intervention at the policy-level. The role of healthcare professionals in this position may be to advocate for people who are living in these circumstances and create safe spaces where they can seek further support without being retraumatised.

Symptom-severity directed solutions may also focus on rebuilding trust between healthcare services and Black communities. It is essential that Black people are made to feel safe within the healthcare systems so that they are no longer fearful of opportunities for support from mental health professionals. Part of rebuilding this trust may involve healthcare professionals having more cultural awareness about the context of historical racism in the medical professionals and cultural humility in interactions with Black people. The term cultural humility is used with the intention of differentiating it from other terms that suggest the possibility of mastering the ability to act in an informed and sensitive manner in response to cultural ‘difference’, for example ‘cultural competence’ (Fisher-Borne et al., 2015) . Cultural humility refers to adopting a position of noticing and acknowledging inequalities within the structures in which we are embedded. The notion of anti-racist practice takes this one step further, by advancing from one holding a culturally sensitive position to one actively engaging in action that challenges systemic racism. Having care options available that specifically meet the needs of Black people may demonstrate to them that their lives are equally valued by healthcare professionals.

Targeted solutions for addressing the misperceptions of mental health professionals are also necessary to ensure that disparities in health inequalities are not founded on racist beliefs and attitudes. There has been a popular trend towards unconscious bias training, which has been shown to increase awareness of implicit biases however there is not consistent evidence of it effectively reducing racially-biased behaviour (Atewologun et al., 2018). This may be because the concept of unconscious bias implies that biases are inevitable, unchangeable and can be forgotten about, which relieves people of the responsibility to address them (Tate & Page, 2018). Alternative and more explicit approaches that increase accountability on healthcare professionals and mental health services to address systemic racism should be considered. Recent research has suggested that innovative techniques such as virtual reality might be helpful for changing behaviour (Banakou et al., 2016; Hasler et al., 2017).

Limitations of the model

This model has been developed as a working model that suggests relationships between various contextual factors based on the current evidence base, however it is limited in the degree to which it can confirm directionality. This model would benefit from further research to directly assess how various factors interact with one another, and to determine directions of causality. This would allow for more specifically targeted solution to be developed and potentially increase the effectiveness of future interventions.

The model also does not consider the ethnicity of the healthcare professionals conducting the assessments. This could be important to consider as the ethnicity of the healthcare professional might be related to how they are influenced by the person being assessed being Black, and also influence that way in which the Black person perceives and interacts with the healthcare professionals. Getting a better understanding of the experiences of people who have been detained under the mental health act and healthcare professionals from a range of ethnic groups would be helpful for gaining a richer understanding of how race interacts in this process. Furthermore a greater consideration of intersectionality might add more nuance to the understanding.

Finally, the proposed model may not be fully developed enough to encompass all relevant contextual factors. Input from people involved in the decision-making process and people with experience of being detained would be valuable for identifying missing factors, processes or mechanisms and add value to the model. Furthermore, of factors might be at play for Black people who hold multiple identities, such as Black women. Despite research showing that ethnic disparities in rates of sectioning are considerably high for women of Black compared to white ethnicity, the proposed model also has not considered the influence of gender on the likelihood of being sectioned. It is well documented that experiencing the interaction of multiple oppressed identities such as race and gender can lead one to be victim to simultaneous types of discrimination; a concept described as intersectionality. In regard to Black women, negative stereotypical tropes such as ‘strong Black woman’ and ‘angry Black woman’ may influence both the likelihood that Black women will seek support, but also clinical professionals’ assessment of risk.

The ‘strong Black woman’ trope is not necessarily a harmful narrative in itself; some women have reported finding the notion of inherent strength to be supportive, self-sustaining and encouraging during difficult times. However, in contexts where experiencing mental health problems and/or seeking help might be interpreted as indicating weakness, the stereotype may be unhelpful (Abrams et al., 2019). This could impact how likely some Back women are to seek support for experiences of mental health problems, particularly at earlier stages of illness when they might not be leading to impaired functioning; it could be possible that help-seeking may feel as though is it only appropriate when no longer able to cope.

The ‘angry Black woman’ trope is strongly perpetuated throughout media (Jones, 2004). Similarly to the way in which Black men can be perceived as more dangerous by virtue of their race, Black women may be more likely to perceived as unruly and volatile in their nature and thus in need of institutional control (Morgan

& Bennett, 2006). As a result of this, clinicians conducting risk assessments may be more likely to deem compulsory detention to be necessary.

These are just two of the common stereotypical narratives about Black women that might impact care seeking and care offered. The construct of intersectionality and intersectional experiences are complex and worthy of further focused exploration to understand Black women’s experiences. An intersectional analysis of the factors leading to disparities in sectioning could highlight important nuances in pathway to compulsory detention for Black women.

References

Abdelghaffar, W., Ouali, U., Jomli, R., Zgueb, Y., & Nacef, F. (2018). Post-traumatic stress disorder in first episode psychosis: Prevalence and related factors. *Clinical Schizophrenia & related psychoses, 12*(3), 105-112B.

Abrams, J. A., Hill, A., & Maxwell, M. (2019). Underneath the mask of the strong Black woman schema: Disentangling influences of strength and self-silencing on depressive symptoms among US Black women. *Sex roles, 80*(9-10), 517-526.

Ajnakina, O., Lally, J., Di Forti, M., Kolliakou, A., Gardner-Sood, P., Lopez-Morinigo, J., Dazzan, P., Pariante, C. M., Mondelli, V., MacCabe, J., David, A. S., Gaughran, F., Murray, R. M., & Vassos, E. (2017, Sep). Patterns of illness and care over the 5 years following onset of psychosis in different ethnic groups; the GAP-5 study. *Soc Psychiatry Psychiatr Epidemiol, 52*(9), 1101-1111. https://doi.org/10.1007/s00127-017-1417-6

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open, 5*(3).

Alang, S. M., & McAlpine, D. D. (2018). Pathways to Mental Health Services and Perceptions about the Effectiveness of Treatment. *Society and Mental Health*, 2156869318802341.

Allen, S., & McCusker, P. (2020). A Hidden Dynamic: Examining the Impact of Fear on Mental Health Officers' Decisions to Use Powers of Compulsory Detention. *Practice*, 1-15. https://doi.org/10.1080/09503153.2020.1782873

Anderson, K., Fuhrer, R., & Malla, A. (2010). The pathways to mental health care of first-episode psychosis patients: a systematic review. *Psychological medicine, 40*(10), 1585-1597.

Angiolini, E. (2017). *Report of the independent review of deaths and serious incidents in police custody*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

Atewologun, D., Cornish, T., & Tresh, F. (2018). *Unconscious bias training: An assessment of the evidence for effectiveness* (113). https://www.equalityhumanrights.com/sites/default/files/research-report-113-unconcious-bais-training-an-assessment-of-the-evidence-for-effectiveness-pdf.pdf

Banakou, D., Hanumanthu, P. D., & Slater, M. (2016). Virtual Embodiment of White People in a Black Virtual Body Leads to a Sustained Reduction in Their Implicit Racial Bias. *Frontiers in human neuroscience, 10*, 601-601. https://doi.org/10.3389/fnhum.2016.00601

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (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.

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis and hospitalisation: A review of the literature. *Clinical Psychology Review, 33*(4), 526-538.

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2015). Trauma in relation to psychosis and hospital experiences: The role of past trauma and attachment. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(3), 227-239.

Bhugra, D. (2005). Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants. *Acta Psychiatrica Scandinavica, 111*(2), 84-93.

Bindman, J., Tighe, J., Thornicroft, G., & Leese, M. (2002, Jul). Poverty, poor services, and compulsory psychiatric admission in England. *Soc Psychiatry Psychiatr Epidemiol, 37*(7), 341-345. https://doi.org/10.1007/s00127-002-0558-3

Blair, I. V., Steiner, J. F., Fairclough, D. L., Hanratty, R., Price, D. W., Hirsh, H. K., Wright, L. A., Bronsert, M., Karimkhani, E., & Magid, D. J. (2013). Clinicians' implicit ethnic/racial bias and perceptions of care among Black and Latino patients. *The Annals of Family Medicine, 11*(1), 43-52.

Bowers, L., Chaplin, R., Quirk, A., & Lelliott, P. (2009). A conceptual model of the aims and functions of acute inpatient psychiatry. *Journal of mental Health, 18*(4), 316-325.

Boydell, J., Bebbington, P., Bhavsar, V., Kravariti, E., van Os, J., Murray, R. M., & Dutta, R. (2013). Unemployment, ethnicity and psychosis. *Acta Psychiatrica Scandinavica, 127*(3), 202-209.

Buckley, P. F., Miller, B. J., Lehrer, D. S., & Castle, D. J. (2008). Psychiatric comorbidities and schizophrenia. *Schizophrenia Bulletin, 35*(2), 383-402.

Care Quality Commission. (2011). *Count me in 2010*. http://webarchive.nationalarchives.gov.uk/20110504143648/http://www.cqc.org.uk/_db/_documents/Count_me_in_2010_FINAL_(tagged).pdf

Care Quality Commission. (2018). *Monitoring the Mental Health Act in 2016/17*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/687252/CQC_MHA2017_ACCESSIBLE.pdf

Codjoe, L., Barber, S., & Thornicroft, G. (2019). Tackling inequalities: a partnership between mental health services and black faith communities. *Journal of* *mental Health*, *28*(3), 225-228. https://doi.org/10.1080/09638237.2019.1608933

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The Cost of Racism for People of Color: Contextualizing Experiences of Discrimination* (pp. 249-272). American Psychological Association.

Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *American journal of public health*, *102*(5), 979-987.

Corrigan, P. W., Schmidt, A., Bink, A. B., Nieweglowski, K., Al-Khouja, M. A., Qin, S., & Discont, S. (2017, Oct). Changing public stigma with continuum beliefs. *J Ment Health*, *26*(5), 411-418. https://doi.org/10.1080/09638237.2016.1207224

Crenshaw, K. W. (2017). *On intersectionality: Essential writings*. The New Press.

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*. http://webarchive.nationalarchives.gov.uk/20130123204153tf_/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Department of Health and Social Care. (2019a). *Independent Review of the Mental Health Act 1983: Supporting documents* (The Independent Review of the Mental Health Act 1983, Issue. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

Department of Health and Social Care. (2019b). *Modernising the Mental Health Act: increasing choice, reducing compulsion* (The Independent Review of the Mental Health Act 1983, Issue. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Fung, W. L. A., & Holloway, J. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. *Psychological medicine, 36*(11), 1541-1550.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015, 2015/02/17). From Mastery to Accountability: Cultural Humility as an Alternative to Cultural Competence. *Social Work Education*, *34*(2), 165-181. https://doi.org/10.1080/02615479.2014.977244

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BMC medical ethics, 18*(1), 19-19. https://doi.org/10.1186/s12910-017-0179-8

Fornells-Ambrojo, M., Gracie, A., Brewin, C. R., & Hardy, A. (2016). Narrowing the focus on the assessment of psychosis-related PTSD: A methodologically orientated systematic review. *European journal of psychotraumatology, 7*(1), 32095.

Gamble, V. N. (1993, Nov-Dec). A legacy of distrust: African Americans and medical research. *Am J Prev Med, 9*(6 Suppl), 35-38. https://www.ncbi.nlm.nih.gov/pubmed/8123285

Ghali, S., Fisher, H. L., Joyce, J., Major, B., Hobbs, L., Soni, S., Chisholm, B., Rahaman, N., Papada, P., & Lawrence, J. (2013). Ethnic variations in pathways into early intervention services for psychosis. *The British Journal of Psychiatry, 202*(4), 277-283.

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of general internal medicine, 22*(9), 1231-1238.

Halvorsrud, K., Nazroo, J., Otis, M., Hajdukova, E. B., & Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC medicine, 16*(1), 223.

Hasler, B. S., Spanlang, B., & Slater, M. (2017). Virtual race transformation reverses racial in-group bias. *PloS one, 12*(4), e0174965. https://doi.org/10.1371/journal.pone.0174965

Henehan, K., & Rose, H. (2018). *Opportunity Knocks? Exploring pay penalties among the UK's ethnic minorities*. https://www.resolutionfoundation.org/app/uploads/2018/07/Opportunities-Knocked.pdf

Jefferies-Sewell, K., Sharma, S., Gale, T. M., Hawley, C. J., Georgiou, G. J., & Laws, K. R. (2015, 2015/01/02). To admit or not to admit? The effect of framing on risk assessment decision making in psychiatrists. *Journal of mental Health, 24*(1), 20-23. https://doi.org/10.3109/09638237.2014.951477

John Hopkins Medicine. (n.d.). *The Legacy of Henrietta Lacks: Upholding the Highest Bioethical Standards*. Retrieved 22nd July 2020 from https://www.hopkinsmedicine.org/henriettalacks/index.html

Joint Commissioning Panel for Mental Health. (2014). *Guidance for commissioners of mental health services for people from black and minority ethnic communities*. https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf

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Katsakou, C., Rose, D., Amos, T., Bowers, L., McCabe, R., Oliver, D., Wykes, T., & Priebe, S. (2012). Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. *Social psychiatry and psychiatric epidemiology, 47*(7), 1169-1179.

Khan, O. (2015). *The 2015 Budget: Effects on Black and minority ethnic people*. https://www.runnymedetrust.org/uploads/The%202015%20Budget%20Effect%20on%20BME%20RunnymedeTrust%2027thJuly2015.pdf

Khan, O. (2020). *The Colour of Money: How racial inequalities obstruct a fair and resilient economy*. https://www.runnymedetrust.org/uploads/publications/pdfs/2020%20reports/The%20Colour%20of%20Money%20Report.pdf

Kingsford, R., & Webber, M. (2010, Sep). Social deprivation and the outcomes of crisis resolution and home treatment for people with mental health problems: a historical cohort study. *Health Soc Care Community, 18*(5), 456-464. https://doi.org/10.1111/j.1365-2524.2010.00918.x

Kirkbride, J. B., Jones, P. B., Ullrich, S., & Coid, J. W. (2014). Social deprivation, inequality, and the neighborhood-level incidence of psychotic syndromes in East London. *Schizophrenia Bulletin, 40*(1), 169-180. https://academic.oup.com/schizophreniabulletin/article/40/1/169/1875480

Knight, M., Bunch, K., Tuffnell, D., Shakespeare, J., Kotnis, R., Kenyon, S., & Kurinczuk, J. J. (Eds.). (2019). *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17*. MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford.

Lawlor, C., Johnson, S., Cole, L., & Howard, L. M. (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.

Lloyd-Evans, B., & Johnson, S. (2019). Community alternatives to inpatient admissions in psychiatry. *World Psychiatry, 18*(1), 31.

Lu, W., Mueser, K. T., Rosenberg, S. D., Yanos, P. T., & Mahmoud, N. (2017). Posttraumatic reactions to psychosis: A qualitative analysis. *Frontiers in psychiatry, 8*, 129.

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).

Mind. (2019). *Discrimination in Mental Health Services*. Retrieved 13th July 2020 from https://www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-june-2019/discrimination-in-mental-health-services/

Minsky, S. K., Lu, W., Silverstein, S. M., Gara, M., Gottlieb, J. D., & Mueser, K. T. (2015). Service use and self-reported symptoms among persons with positive PTSD screens and serious mental illness. *Psychiatric Services, 66*(8), 845-850.

Morgan, C., Fearon, P., Hutchinson, G., McKENZIE, K., Lappin, J. M., Abdul-Al, R., Morgan, K., Dazzan, P., Boydell, J., & Harrison, G. (2006). Duration of untreated psychosis and ethnicity in the AESOP first-onset psychosis study. *Psychological medicine, 36*(2), 239-247.

Morgan, C., Fisher, H., Hutchinson, G., Kirkbride, J., Craig, T. K., Morgan, K., Dazzan, P., Boydell, J., Doody, G. A., & Jones, P. B. (2009). Ethnicity, social disadvantage and psychotic-like experiences in a healthy population based sample. *Acta Psychiatrica Scandinavica*, *119*(3), 226-235.

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., Dazzan, P., Boydell, J., McKenzie, K., & Harrison, G. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission: Report from the AeSOP study. *The British Journal of Psychiatry, 186*(4), 281-289.

Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: the bridge between social science and psychiatry. *Social Science & Medicine, 58*(4), 739-752.

Morgan, M., & Bennett, D. (2006). Getting off of Black women's backs: Love her or leave her alone. *Du Bois Review: Social Science Research on Race, 3*(2), 485-502.

National Institute for Mental Health in England. (2003). *Inside/Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. https://webarchive.nationalarchives.gov.uk/20130105200229/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf

National Mental Health Development Unit. (2009). *Delivering Race Equality in Mental Health Care: a review*. https://webarchive.nationalarchives.gov.uk/20121103021354/http://www.nmhdu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf

NHS Digital. (2019). *Mental Health Act Statistics. Annual Figures. England, 2018-19*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures#summary

Oduola, S., Craig, T. K., Das-Munshi, J., Bourque, F., Gayer-Anderson, C., & Morgan, C. (2019). Compulsory admission at first presentation to services for psychosis: does ethnicity still matter? Findings from two population-based studies of first episode psychosis. *Social psychiatry and psychiatric epidemiology*, 1-11.

Oduola, S., Das-Munshi, J., Bourque, F., Gayer-Anderson, C., Tsang, J., Murray, R. M., Craig, T. K., & Morgan, C. (2019). Change in incidence rates for psychosis in different ethnic groups in south London: findings from the Clinical Record Interactive Search-First Episode Psychosis (CRIS-FEP) study. *Psychological medicine*, 1-10.

Office for National Statistics. (2016). *Respondents aged 16 to 64 broken down by age groups showing employed/unemployed count and rate and duration of unemployment by sex, NS-SEC, ethnicity, highest qualification family types, disabled and whether respondent has a learning difficulty or learning disability: July 2015 to June 2015* Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/adhocs/006244respondentsaged16to64brokendownbyagegroupsshowingemployedunemployedcountandrateanddurationofunemploymentbysexnssecethnicityhighestqualificationfamilytypesdisabledandwhetherrespondenthasalearningdifficultyorlearningdisabilityjuly2015tojune2015

Office for National Statistics. (2020). *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020*. Office for National Statistics. Retrieved 13th July 2020 from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

Penner, L. A., Dovidio, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. *Journal of experimental social psychology, 46*(2), 436-440.

Peris, T. S., Teachman, B. A., & Nosek, B. A. (2008). Implicit and explicit stigma of mental illness: Links to clinical care. *The Journal of nervous and mental disease, 196*(10), 752-760.

Prins, H. A., Backer-Holst, T., Francis, E., & Keitch, I. (1993). *Report of the Committee of Inquiry Into the Death in Broadmoor Hospital of Orville Blackwood, and a Review of the Deaths of Two Other Afro-Caribbean Patients: "Big, Black and Dangerous?"*.

Reichert, A., & Jacobs, R. (2018, Apr). Socioeconomic inequalities in duration of untreated psychosis: evidence from administrative data in England. *Psychol Med, 48*(5), 822-833. https://doi.org/10.1017/S0033291717002197

Rodrigues, R., & Anderson, K. K. (2017). The traumatic experience of first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia research, 189*, 27-36.

Rodrigues, R., MacDougall, A. G., Zou, G., Lebenbaum, M., Kurdyak, P., Li, L., Shariff, S. Z., & Anderson, K. K. (2019). Involuntary hospitalization among young people with early psychosis: A population-based study using health administrative data. *Schizophrenia research, 208*, 276-284.

Sabin, J. A., & Greenwald, A. G. (2012). The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. *American journal of public health, 102*(5), 988-995.

Sabin, J. A., Rivara, F. P., & Greenwald, A. G. (2008). Physician implicit attitudes and stereotypes about race and quality of medical care. *Medical care*, 678-685.

Sartin, J. S. (2004). J. Marion Sims, the father of gynecology: Hero or villain? *Southern medical journal, 97*(5), 500-506.

Schizophrenia Commission. (2012). *The abandoned illness: A report by the Schizophrenia Commission*. https://www.rethink.org/media/2637/the-abandoned-illness-final.pdf

Schofield, P., Kordowicz, M., Pennycooke, E., & Armstrong, D. (2019). Ethnic differences in psychosis—Lay epidemiology explanations. *Health Expectations*.

Sharp, D., & Atherton, S. (2007). To Serve and Protect?: The Experiences of Policing in the Community of Young People from Black and Other Ethnic Minority Groups. *The British Journal of Criminology, 47*(5), 746-763. https://doi.org/10.1093/bjc/azm024

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2013). 'Our community is the worst': the influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *Int J Soc Psychiatry, 59*(6), 535-544. https://doi.org/10.1177/0020764012443759

Shim, R. S., & Compton, M. T. (2020, Jan). The Social Determinants of Mental Health: Psychiatrists' Roles in Addressing Discrimination and Food Insecurity. *Focus (Am Psychiatr Publ), 18*(1), 25-30. https://doi.org/10.1176/appi.focus.20190035

Singh, S., Croudace, T., Beck, A., & Harrison, G. (1998). Perceived ethnicity and the risk of compulsory admission. *Social psychiatry and psychiatric epidemiology, 33*(1), 39-44.

Singh, S. P., Brown, L., Winsper, C., Gajwani, R., Islam, Z., Jasani, R., Parsons, H., Rabbie-Khan, F., & Birchwood, M. (2015). Ethnicity and pathways to care during first episode psychosis: the role of cultural illness attributions. *BMC psychiatry, 15*(1), 287.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M., Nadal, K. L., & Esquilin, M. (2007, May-Jun). Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol, 62*(4), 271-286. https://doi.org/10.1037/0003-066X.62.4.271

Sündermann, O., Onwumere, J., Kane, F., Morgan, C., & Kuipers, E. (2014). Social networks and support in first-episode psychosis: exploring the role of loneliness and anxiety. *Social psychiatry and psychiatric epidemiology, 49*(3), 359-366.

Sundquist, K., & Ahlen, H. (2006, Dec). Neighbourhood income and mental health: a multilevel follow-up study of psychiatric hospital admissions among 4.5 million women and men. *Health Place, 12*(4), 594-602. https://doi.org/10.1016/j.healthplace.2005.08.011

Szmukler, G., & Holloway, F. (2000). Reform of the Mental Health Act: health or safety? *The British Journal of Psychiatry, 177*(3), 196-200.

Tate, S. A., & Page, D. (2018, 2018/01/02). Whiteliness and institutional racism: hiding behind (un)conscious bias. *Ethics and Education, 13*(1), 141-155. https://doi.org/10.1080/17449642.2018.1428718

Upthegrove, R., Atulomah, O., Brunet, K., & Chawla, R. (2013). Cultural and social influences of negative illness appraisals in first-episode psychosis. *Early intervention in psychiatry, 7*(4), 399-406.

van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., Griffin, J. M., Fu, S. S., & Perry, S. (2011, Apr 1). The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making. *Du Bois Rev, 8*(1), 199-218. https://doi.org/10.1017/S1742058X11000191

Vernon, P. (2020). Thirty Years of Black History Month and Thirty Years of Overrepresentation in the Mental Health System. In M. Richard, C. Karen, & S. R. Theodore (Eds.), *The International Handbook of Black Community Mental Health* (pp. 137-148). Emerald Publishing Limited. https://doi.org/10.1108/978-1-83909-964-920201010

Walker, S. (2020). Systemic Racism: Big, Black, Mad and Dangerous in the Criminal Justice System. In M. Richard, C. Karen, & S. R. Theodore (Eds.), *The International Handbook of Black Community Mental Health* (pp. 41-60). Emerald Publishing Limited. https://doi.org/10.1108/978-1-83909-964-920201004

Walker, S., Mackay, E., Barnett, P., Rains, L. S., Leverton, M., Dalton-Locke, C., Trevillion, K., Lloyd-Evans, B., & Johnson, S. (2019). Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis. *The Lancet Psychiatry, 6*(12), 1039-1053.

Webber, M., & Huxley, P. (2004). Social exclusion and risk of emergency compulsory admission. A case-control study. *Social psychiatry and psychiatric epidemiology, 39*(12), 1000-1009.

Weich, S., McBride, O., Twigg, L., Duncan, C., Keown, P., Crepaz-Keay, D., Cyhlarova, E., Parsons, H., Scott, J., & Bhui, K. (2017). Variation in compulsory psychiatric inpatient admission in England: A cross-classified, multilevel analysis. *The Lancet Psychiatry, 4*(8), 619-626.

Wilson, M. (2010). *Delivering Race Equality Action Plan: a five year review*. http://data.parliament.uk/DepositedPapers/Files/DEP2014-0975/PQ202552_PQ202500_-_Report.pdf

Women’s Budget Group. (2017). *Intersecting Inequalities: The impact of austerity on Black and Minority Ethnic women in the UK*. https://www.intersecting-inequalities.com/copy-of-report

Table 1 Summary of the contexts that influence the mechanisms determining whether healthcare professionals decide to compulsorily detain a Black person

Theme	Brief description of context	Mechanism influenced	
		Severity of symptoms	Perceived need for compulsory detention
Socioeconomic deprivation, exclusion and poverty	Deprivation, exclusion and poverty limit access to resources and social integration, which increases psychosocial stress	✓	
	Having more complex needs, including poor housing and financial instability might may be viewed as a greater risk by healthcare professionals.		✓
	Having migrated to the UK, having a less well-established social network is associated with increased psychosocial stress.	✓	
	Unemployment is associated with a longer duration of untreated psychosis.	✓	
Cultural expectations of mental health, service provision and help-seeking	Seeking help from a faith-based practitioner because of mistrust of mental health services could delay access to mental health professionals	✓	
	Being supported by faith-based practitioners may lead the person to decline informal pathways into mental health services		✓
	Fear of services may lead to avoidance of mental health support	✓	✓
	Lack of responsiveness from GP could reinforce mistrust of the healthcare system or reinforce that professional support is not essential	✓	✓
	Cultural stigma about mental health problems may reduce family support or activate one’s own negative beliefs, increasing psychosocial stress.	✓	
	Hostile, dismissive or avoidant attitudes resulting from self-stigma, may be perceived as lack of insight or as threatening.		✓
Racially biased risk-aversion and decision-making	Black people are perceived as being more dangerous.		✓
	Racial biases influence decision-making, particularly under uncertain and pressurised circumstances.		✓
	Microaggressions from healthcare professionals may provoke a hostile response from the Black person being assessed.		✓

Part II: Empirical paper

Black women's experiences of the decision being made to compulsorily detain them in hospital

Abstract

Aims: In the UK, Black people are more likely to be compulsorily detained than their white British counterparts. While many studies have enumerated this difference, there is limited understanding of the causes of this disparity. Furthermore, little emphasis has been placed on the experiences and perspectives of Black women specifically who are largely disproportionately represented in this population. This study aimed to understand how Black women make sense of their experiences of being compulsorily detained and the factors that they believed influenced the decision for them to be detained.

Method: This used a semi-structured interview to explore four Black women's experiences of the sectioning process, being involuntarily hospitalised and how theirs and others' personal characteristics influenced decision-making. The women completed visual analogue scales (VAS) to indicate the degree to which they believed pre-defined factors influenced the decision-making process. The interview data were analysed using an interpretative phenomenological analysis (IPA) approach.

Results: Five themes were identified from the interview transcripts. Two themes related to the sectioning process (feeling vulnerable, why did this happen to me?), and three themes to the experience of being hospitalised (an uncontaining, unsafe environment, pulling through: internal journey, pulled through by relationships). Most of the women identified their own behaviour and psychological wellbeing as being the main reason for being detained.

Discussion: The women's experiences of being detained were in line with previous research, and they believed that their need for further support was the main influencing factor. Clinicians are encouraged to hold a compassionate stance and

form meaningful therapeutic relationships with people throughout the sectioning. Further research would be required to fully explore the relationships between racism and sectioning rates.

Introduction

Being compulsorily detained for mental health assessment and treatment can be highly distressing, with aversive experiences being associated with humiliation, loss of dignity and respect, and a sense of violation (Burnett et al., 1999; Chambers et al., 2014; Lu et al., 2017; Nyttingnes et al., 2016). Psychosis-related post-traumatic stress disorder (PTSD) can develop from the traumatic experience of psychotic symptoms and the involuntary and forceful aspects of its treatment (Berry et al., 2013; Rodrigues & Anderson, 2017). With Black people being more likely than their White counterparts to experience compulsory admission as negative (42.9% and 29.7% of patients, respectively; Katsakou et al., 2012), the longstanding, disproportionally high rates of compulsory detention of Black people in the UK (Bhui et al., 2003; Cole et al., 1995; Gajwani et al., 2016) is of great concern.

During 2018-2019 in England, people of Black ethnic identity were compulsorily detained at a rate four times greater than their White counterparts, and placed on a community treatment order at more than eight times the rate of their White equivalents (NHS Digital, 2019). The narrative around ethnic disparities in compulsory admission often centres around young Black men, particularly in response to a number of high-profile cases regarding the care that they receive. In the UK, Black men can be perceived as more threatening than others, views which have been bolstered by government reports such as Prins et al. (1993) “Big Black and Dangerous” report of the deaths of Orville Blackwood and two other Black men in Broadmoor Hospital. While the focused concern on engaging in a critical analysis of the care that they receive as a result of the compulsory mental health systems in place is justifiable, the experiences of Black women remain somewhat overlooked.

Ethnic disparities in compulsory admission are even more stark when the intersection with gender is explored. White British women are four times more likely than Black women to be admitted to a crisis house rather than hospital (Lawlor et al., 2010), whereas the odds of being compulsorily detained are three to four times greater for Black Caribbean women, three to five times greater for Black British/Black Other women, and a startling five to seven times greater for Black African women (Lawlor et al., 2010; Mann et al., 2014). An equivalent sample of men showed that Black African men are significantly more likely to be compulsorily detained, with odds twice as high as White British men when adjusting for age and diagnosis (Mann et al., 2014).

Ethnic disparities are also observed in women's pathways to services; Black women are two to four times more likely to have a pathway to care involving the police or criminal justice system (Lawlor et al., 2010). These differences are not specific to mental health; ethnic disparities in health-related outcomes also affect Black women in other domains. For example, in the UK, Black women are significantly more likely to die after being treated for breast cancer than white women (Copson et al., 2014) and five times more likely than white British women to die in childbirth (Knight et al., 2019), and four times more likely than white women to die from coronavirus during the recent pandemic (Office for National Statistics, 2020).

Making sense of these differences is challenging. Explanations for these differences are likely to be complex. As described in Part 1, analyses over the past decades have often identified individual-level factors to explain ethnic disparities in mental health outcomes. Factors such as higher prevalence of psychosis (Goater et al., 1999), increased risk of violence (Commander et al., 1999), and low engagement with healthcare services (Singh & Burns, 2006) are examples of some of the frequently identified explanations of why Black people are more likely to be detained (Barnett et al., 2019), however studies tend not to provide hypotheses as why these further disparities exist. The analysis typically conducted has not facilitated a deep understanding of the factors causing and maintaining ethnic disparities in compulsory detention, and therefore has been limited in the solutions it offers. There is little understanding of the systemic factors at the root of the problem, therefore there has been little change in ethnic disparities despite it being extensively documented that inequalities exist.

The government has stated multiple times that it aims to deliver a healthcare with race equality at its core (Department of Health, 2005; Department of Health and Social Care, 2017, 2019b). It is important that there is progression beyond identifying the presence of inequalities to gain meaningful insight into what causes and maintains the disparities, taking into considerations the perspectives and experiences of all key stakeholders involved. Qualitative research methodologies enable in-depth, rich descriptions due to their broad, open-ended nature, therefore are useful for informing the development of hypotheses to better understand mechanisms underlying disparities (Hamilton & Finley, 2019). Responses can be understood in relation to the contexts they are located in, allowing both the individual, researcher and reader to explore how it is that they came to make sense of their experience in the way that they do (Sofaer, 1999). Furthermore, including the first-hand perspectives of experts by experience is key as they are at the centre of healthcare services; they provide an important, unique and invested perspective on what does and doesn’t work well, and why (Tapp et al., 2013).

The decision to compulsorily detain an individual places them in a situation where a great amount of liberty is lost. It is important that professionals involved in the system understand how this is experienced by service users. Several studies have explored service users' experiences of being involuntarily hospitalised. They report that during inpatient admission they felt scared and confused, disempowered with a loss of agency and that the environment varied in how safe and containing it felt (Fenton et al., 2014; Seed et al., 2016). However, how these experiences interact with ethnicity are rarely considered.

In a recent review of qualitative studies exploring the experience of involuntary detention only 17 of 56 studies reported ethnicity and a majority of participants were white British (Akther et al., 2019). In exploring the experiences of people with psychosis, it is important to account for the impact of race and gender given that people's experiences of psychosis-related symptoms are influenced by these characteristics (Haarmans et al., 2016). To our knowledge, there are no studies specifically exploring the experiences of Black women with psychosis who have being involuntarily hospitalised in the UK.

In light of this, this research study aimed to extend the current literature by exploring Black women's experiences of the decision to be sectioned. An interpretative phenomenological analysis approach was used to understand how Black women make sense of their experiences of being compulsorily detained and the factors that they believed influenced the decision for them to be detained.

Methods

This qualitative study explored Black women's experiences of the decision for them to be compulsorily admitted to hospital. The interview data was analysed using an interpretative phenomenological analysis (IPA) approach. The words ‘race’ and ‘ethnicity’ are often used interchangeably in general spoken language, and this is also reflected within this thesis at times. However, there are distinct differences in the meaning of each of these terms. ‘Race’ is a social categorising structure to which people are ascribed based largely on physical characteristics. For this reason, there can be misunderstanding that racial groups are akin to biological differences and justifiable on the basis of genetic differences, however there is a general consensus of their being greater intra-racial than inter-racial genetic differences (Blakemore, 2019). ‘Ethnicity’ on the other hand, extends beyond physical characteristics to provide a categorising structure based on shared expressions of culture, which encompasses features such as national, religious, spiritual and linguistic origins (Blakemore, 2019).

Interpretative Phenomenological Analysis

Qualitative approaches differ in their epistemological positions and therefore their application. Phenomenological approaches intend to understand how people make sense of their experiences in the world by focusing on “thick”, detailed descriptions of experiences and perspectives using language (Pistrang & Barker, 2012). Through these rich accounts of experiences, the researcher can begin to notice some of the cultural, social and interpersonal factors that, at in least in some part, explain how the individuals come to make sense of the world in the way that they do (Davidsen, 2013).

Interpretative phenomenological analysis (IPA) is a phenomenological analytic technique that seeks to examine and understand an individual’s experience of a phenomenon and the meaning that their specific perspective holds within the context (Smith & Osborn, 2015). It offers a complete, in-depth analysis, recognising the central role of the researcher in understanding the participants interpretations while also privileging the individual in recounting their lived experience (Pringle et al., 2011).

By design, it prioritises the meaning of the participants' lived experience and locates this within the contexts in which the individual is embedded. The IPA approach is therefore well suited for exploring complex and emotionally salient phenomena that underlie health inequalities. By drawing on the philosophical principles of phenomenology, hermeneutics and ideography, IPA aims "to know in detail what the experience for an individual is like, and what sense this particular individual is making of what is happening to them" (Smith et al., 2009, p. 3).

Another possible analysis approach that could have been used to explore the research question was discourse analysis. Discourse analysis explores, seeing language as functional and constructive. It is interested in how stories are told rather than what is being described in the telling of story, and is useful for examining how language shapes identities and relationships (Starks & Brown Trinidad, 2007) However, as the aim of the research was to gain an understand of what the lived experience meant to the women interviewed, rather than how they spoke of their experience, IPA was selected as analyses technique of choice. This was deemed to be particularly useful for sharing meaningful findings to clinicians and early intervention services who may also benefit from understanding the lived experience of Black women who become detained.

Design

Sample

Six women were identified as eligible for the study by care coordinators using purposive sampling. Two women declined participation; one woman was preparing for her exams so was unable to take part and one woman had recently moved away from the local region. The other four women identified agreed to participate in the study. While I intended to recruit more women to the study, recruitment was forced to stop because of the restrictions in place during the coronavirus pandemic. Given the depth and detail involved in the IPA methodology, the appropriate sample size for a professional doctorate research project is identified as being between four and ten interviews (Smith et al., 2009).

Inclusion criteria

The inclusion and exclusion criteria were designed to ensure that participants were recruited from a reasonably homogenous sample with an experience of the phenomenon being studied (Smith et al., 2009). The inclusion criteria were as follows:

- Women who self-identified as being of Black ethnicity
- At least 18 years old
- Under the care of an Early Intervention in Psychosis team
- Compulsorily detained under the Mental Health Act in the last 12 months and discharged from the Mental Health Act Section for at least 1 month. This time period was selected to increase the likelihood of the women being able to remember the events leading up to and during their detention. The 1 month window since detention was to ensure that any potential trauma symptoms

reported had been experienced for a sufficient amount of time to increase the validity of them being interpreted as indicators of PTSD.

- Having a mental state sufficiently stable to participate in research. This was determined in the first instance by the referring clinician, and by the researcher during initial contact
- Able to read and speak English to provide informed consent and complete questionnaire measures
- Without a primary diagnosis of intellectual disability, head injury, substance misuse, or known organic cause for psychosis. This was to ensure that they were representative of the typical population under the care of Early Intervention Services, where findings were intended to be disseminated. It should be considered that this could be overly exclusive if people with the above diagnoses or health conditions experience the same detention processes as those without

Women without the capacity to provide informed consent were excluded from the study.

Interview schedule

In accordance with IPA methodology (Smith et al., 2009), the research team devised a semi-structured interview schedule (see Appendix 1) to facilitate the researcher's and participant's engagement in a dialogue that covers all topics related to the research conversation. The semi-structured interview was designed to be flexible and responsive to the conversations that unfolded on from participants' responses. With this structure, the researcher could generate follow up questions to further explore topics that were not sufficiently covered in the interview schedule, while using the schedule to remain connected with the aims of the interview.

Development of the interview schedule

The interview schedule was developed by the research team in consultation with experts by profession and experts by experience, including Black women with a diagnosis of psychosis who had experience of being compulsorily detained. The first draft comprised of initial questions proposed by the research team that derived from recommendations for further research from quantitative studies of ethnic disparities in compulsory detention. The team also considered which questions would be important to generate information relevant to the aims of the study. The research team identified key sections of the interview schedule including questions exploring demographic characteristics, experiences of compulsory detention, and perspectives on the impact of race and gender on experiences of detention.

Consultation was then sought to ensure the questions aligned with the aims of the study, to identify whether any important topics were missing, and to ensure that questions were asked in a meaningful, yet sensitive manner. This took place in three stages; (1) meeting with an expert in qualitative research to refine the style of questioning, (2) meeting with an expert in race-relations research and an approved mental health practitioner to ensure topics pertinent to ethnicity and the detention process were including, and (3) meeting with five experts-by-experience, two of whom were Black women with experience of being compulsorily detained. The wording of interview questions and the structure of the schedule was refined on the basis of these consultations. Further details of the consultations that took place are reported in (see Appendix 2).

The schedule was developed holding the principles of IPA in mind. The interview questions helped the researcher to situate the participant within their context. Furthermore, the IPA methodology encourages the researcher to facilitate the conversation in a way that enables the participant to share their experience as a narrative. The questions were intentionally broad and open-ended to allow participants to have the space to expand on the complexities of their lived experience, rather than being too constrained by limitations placed on the conversation by the predefined research questions.

The researcher recorded reflections on their experience of the interviews immediately after meeting with each participant. This reflective journal shaped the researcher reflexive considerations when analysing the conversations.

Format of the interview schedule

The interview schedule comprised of six main sections. Participants were first asked to state their demographic characteristics, including their age, ethnicity, religious beliefs, and gender (see Appendix 3). In the second section of the interview, participants were asked to recall their experience of being sectioned. This was followed by a section focused on how the women made sense of their experience, including their perspectives on the role of other people in the decision for them to be sectioned. The fourth section involved reflection on the experience of being sectioned and the learning that can be taken from it, including what was more and less helpful for them throughout the sectioning process. The fifth section invited participants to share their perspectives on the influence of their own and others' personal characteristics on the decision for them to be detained.

Following the main interview discussion, participants were asked to rate how much they believed a range of factors each influenced the decision being made to them to be detained using a series of 10cm Likert scale ratings (0 = not at all, 10 = completely). The rating scales were included in anticipation that it might be difficult to articulate these issues in the open-ended structure of the interview and participants might be reluctant to share ideas around structural racism.

Trauma questionnaires

As being compulsorily detained has been associated with experiencing trauma-related symptoms (Abdelghaffar et al., 2018; Fornells-Ambrojo et al., 2016), the researcher screened participants for trauma symptoms using two questionnaires; the Trauma and Life Events (TALE) checklist (Carr et al., 2018) and the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018).

The TALE is a 21-item checklist (see Appendix 4) that was used to assess the prevalence of traumatic experiences. It asked whether participants have experienced common traumatic or stressful life events and which of them have had the most impact. Importantly, one item asked specifically about experiences of psychosis-related trauma. Higher scores on the TALE indicated an increased frequency of traumatic experiences. The TALE has moderate psychometric acceptability for use with people with psychosis, with excellent reliability and convergent validity (Carr et al., 2018)

If participants reported traumatic events in the TALE checklist, the International Trauma Questionnaire (ITQ) (Cloitre et al., 2018) was used to assess their impact by measuring the presence of PTSD symptoms (see Appendix 5). The ITQ is a brief tool comprised of 12-items that relate to the diagnostic criteria for post-traumatic stress disorder (PTSD) and Complex-PTSD, as specified by the ICD-11. Participants were asked to hold in mind the traumatic event that they identified as having the most impact in the TALE while rating how much they have been bothered by six PTSD symptoms in the last month. Ratings were made on a five-point Likert scale ranging from 0 (‘Not at all’) to 4 (‘Extremely’). Higher scores indicate a greater level of distress associated with experiencing trauma-related symptoms.

Recruitment

The researcher informed the four EIS teams in the recruitment trust of the project by attending weekly team meetings to share details of the study, providing them with copies of the recruitment flyer (see Appendix 6) and inviting them to identify women in their care who meet the inclusion criteria. Potential participants were approached by their care-coordinator who sought permission for the researcher to contact them.

With permission, the researcher spoke with participants over the telephone, giving them a brief description of the study and what participation involved. Potential participants were able to ask questions during this phone call, and the researcher emailed them the full information sheet for their consideration (see Appendix 7). After having at least 24 hours to read the information sheet, the researcher scheduled a date, time and location for the interview to take place with participants who wanted to participate in the study.

Participants

The participants were all self-identified Black women who had been compulsorily detained in the 12 months prior to the interview. At the beginning of the interview, each woman specified which subcategory of Black ethnicity they identified as belonging to and their country of origin. Their ages ranged between 19 and 54 at the time of interview, and they had been detained between two and five months prior to the interviews taking place. While the interviews did not focus on the women's relationships circumstances, it was noticed that none of the women were in relationships. While direction of causality is unclear, this could be a possible indication that not having the support of a partner contributed to worsening of mental health problems and/or personal circumstances. Names and potential personal identifiable information (e.g. number of children, country of origin, and hospital(s) admitted to) were anonymised to ensure participant confidentiality. The characteristics of the four women who participated are detailed below.

Patricia

Patricia is a 54-year-old woman who identifies as Black British. She travelled from the Congo to the UK where she has been settled for a long time. She is single woman whose Christian faith is important to her. Since becoming unwell she has not been employed. In the TALE questionnaire, Patricia identified that she had experienced 10 out of 20 potentially traumatic experiences, five of which she had experienced more than once. She identified the experience of being unwell and being detained as still affecting her at the time of the interview, rating its impact as a 6/10. The ITQ questionnaire revealed that she met the diagnostic criteria for PTSD and disturbance in self-organisation which indicated that she met the criteria for complex PTSD.

Olivia

Olivia is a 19-year-old woman who identifies as Black Caribbean and African. She was born and raised in the UK, is single, and lives with family members. She identifies as a Christian and her faith is important to her. Olivia was unemployed at the time of the interview. In the TALE questionnaire, she identified that she had experienced 6 out of 20 potentially traumatic experiences, five of which she had experienced more than once. Olivia described that none of these experiences still impacted her at the time of the interview.

Mary

Mary is a 55-year-old woman who identifies as Black African. She travelled to the UK from Zambia many years ago and has been settled in the UK since. She is a single woman who lives in shared housing and was unemployed at the time of the interview. She identifies as a Christian and her faith is important to her. In the TALE questionnaire, Mary identified that she had experienced 12 out of 20 potentially traumatic experiences, all of which she had experienced more than once. She identified that she was still affected by some of her experiences at the time of the interview and met the criteria for PTSD but did not meet the criteria for disturbance in self-organisation or complex PTSD.

Sharon

Sharon is a 45-year-old woman who identifies as Black Caribbean. She is a single woman, born and raised in the UK and living alone. She was self-employed at the time of the interview and identified as being a spiritual person rather than religious. In the TALE, Sharon identified that she had experienced 8 out of 20 potentially traumatic experiences, and one of them more than once. Although she felt as though one of the events still impacted her life at the time of sectioning, the ITQ questionnaire revealed that she did not meet the criteria for PTSD, disturbance in self-organisation or complex PTSD.

Procedure

The researcher endeavoured to carry out all interviews at participants' usual EIS site, however this was not possible for two participants who preferred to have the interviews take place at their homes.

At the beginning of the data collection session, the researcher reviewed the information sheet with participants and answered any questions or concerns raised. Following this, participants were reminded of their right to withdraw from the study at any point prior to data collection and that doing so would not affect their treatment in any way. The researcher gained informed written consent (see Appendix 8) from all participants before proceeding with the interview.

The interview session began by collecting demographic information during which the researcher aimed to build rapport with participants. This was important to create a comfortable space in which the researcher could facilitate a more in-depth, open conversation throughout the remainder of the interview session. The researcher then proceeded to guide the conversation to explore the participant's experience of the time that the decision was made for them to be sectioned and to draw out what factors they felt influenced that decision. Interviews lasted between 45 – 60 minutes and were audio recorded.

After the interview was complete, participants completed the TALE and ITQ questionnaires. The researcher then thanked the women for their participation and debriefed them. During the debrief, participants were offered the opportunity to complete either a mindful breathing or progressive muscle relaxation exercise, should they wish to. Finally, participants received £15 for their time.

Ethical considerations

This study was granted full ethical Health Research Authority (HRA) approval by the London Dulwich Research Ethics Committee (Reference: 19/LO/1584) (see Appendix 9). Approval was also granted by the trust R&D from which participants were recruited (see Appendix 10).

Confidentiality and anonymity of all personal data was maintained throughout the entire study. The researcher generated numerical identification codes for participants to replace names and personal identifiable data were removed during transcription. Once transcribed, audio recordings of the interview were immediately deleted. Personal data was stored in a password protected file on the university computer system and files were only accessible to the researcher.

While it was anticipated that physical harm from study participation was unlikely, it was considered that participants in the study were asked to discuss events that may have been upsetting. Before commencing the study, participants were reminded that they may withdraw at any time, without their care being affected in any way. During the interview, the researcher monitored the participant for signs of distress and asked participants for feedback about their experience regularly throughout the conversation to allow the researcher to assess any negative reactions. The researcher ensured sufficient time was spent building rapport early in the interview, and participants’ experiences and emotions were validated and normalized throughout the conversation.

Following, the interview, participants were encouraged to schedule an enjoyable activity and social support following the session, to help manage any lowering of mood. The researcher also ensured that participants had their clinical care co-ordinator’s contact details and an emergency contact number for the service. With the participants permission, the researcher maintained regular communication with the clinical team to maintain a well-informed clinical support network throughout participation in the study.

Data analysis

IPA analysis involves revisiting interviews using an iterative process that guides the researcher from a descriptive to an interpretative analysis. Smith et al. (2009) outlined six steps to achieve this.

Step 1: Reading and re-reading

Each transcript was read and re-read a second time, while noting any initial thoughts and ideas that came to mind. This process served to facilitate re-engagement with the participants and to identify and bracket off the readers own reactions, enabling them to understand the experience as described by the participant.

Step 2: Initial noting

Notes were made about the ways that the participants talked about, made sense of, and thought about the decision made for them to be sectioned (see Appendix 11). Notes were descriptive, interpretative and conceptual in nature; they captured how the participant described things that were important for them, why they were so pertinent, the contexts in which they were important and broader abstract concepts that helped understand the meanings that the participant had ascribed.

Step 3: Developing emergent themes

On the basis of the descriptive, interpretative and conceptual noting, the dataset was summarised into themes which highlighted the connections between key features of the text (see Appendix 12). This process intends to produce a concise outline of what was identified as being important in the initial notes.

Step 4: Searching for connections across emergent themes

Each theme was printed on a small piece of paper and moved around in an attempt to identify relationships between them (see Appendix 13). The clusters of themes that came from this process were labelled and organised in a table with transcript extracts demonstrating each theme (see Appendix 14).

Step 5: Moving to the next case

The process of steps 1 – 4 was repeated for each of the remaining transcripts in turn, with each being treated as independent of the others.

Step 6: Looking for patterns across cases

Theme clusters identified in step 4 of each transcript's analysis were cross-referenced electronically to identify patterns in the participants' experiences (see Appendix 15). This generated superordinate themes that encompassed the themes of each interview and described higher-order concepts that each of the women shared. These themes were organised in a table alongside subthemes related to each theme.

Validity and quality

Yardley (2000) outlined four criteria to determine the validity and quality of qualitative research which I have used to evaluate this study. These criteria include: (1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence, (4) impact and importance.

Sensitivity to context

Yardley (2000) suggested that researchers should be sensitive to the context of the theory underpinning the phenomena being studied, reviewing the existing literature to enable to study to be grounded in the philosophies of the topic being studied. An awareness of the sociocultural context in which the research took place was also essential, alongside acknowledgement of the social context of the researchers and participants' relationships.

In this study, I considered the theoretical context of this research by conducting a review of the existing literature on the topics of ethnic inequalities in healthcare and the relevance of intersectionality (see Part I of the thesis for literature review). When designing the study, I ensured that Black women with the experience of being sectioned informed the wording and structure of interview to ensure that it was sensitively constructed and would explore the participants' perspectives respectfully. I have also ensured that participants' voices are incorporated into this thesis by including quotes and extracts as much as appropriate. Furthermore, I engaged in reflexivity throughout the study.

Commitment and rigour

Yardley (2000) described that commitment in qualitative research refers to full engagement with the research topic and the development of competency in the methods used throughout the research. Rigour relates to the comprehensiveness of the data collection and analysis. I was both academically and personally engaged with the topic of this study, as evident in the literature review and described in my personal reflections (see Reflexive considerations section below). Furthermore, an expert in qualitative research was consulted during the study design and the analysis process carefully followed guidelines for conducting IPA, attending to the participants' understanding of their experiences at all times. Finally, an independent audit (Smith et al., 2009) was conducted by the researcher's supervisor to ensure the validity of notes, emergent themes and theme cluster development.

Transparency and coherence

Yardley (2000) shares the importance of full disclosure of relevant aspects of the research process and demonstrable coherence between the study and the theoretical assumptions underlying the methodology used. I have detailed each stage of the study design and analysis undertaken, linked each of these stages with their methodological underpinning and provided worked examples of the process to demonstrate transparency and coherence in this study.

Impact and importance

Yardley (2000) proposes that a sensitive, thorough analysis is insufficient if its results are not of utility; the intention is to inform and influence others' beliefs and actions. The experiences of Black women who have been sectioned under the mental health act are under-documented, and therefore the ability to have their voices heard in decision-making forums has been limited. This study aims to fill this gap in the literature, while dissemination of its results to early intervention services, conferences, and peer-reviewed journals will ensure that their experiences are more widely considered.

Reflexive considerations

As a key part of the IPA methodology, the researcher must be aware of their positionality in relation to the topic of study and the participants (Smith et al., 2009). This is achieved through the process of reflection. As part of the bracketing process, in this section I have shared my reflections about my identify and personal experiences, with careful consideration of the ways in which they could interact with the research process.

Throughout this research I was aware of the aspects of my identity that I shared with participants of this study. As a Black cis-gendered woman living in the UK, I felt connected with the study participants and their experiences in terms of our ethnicity and gender. I was curious as to whether these characteristics would help me to build rapport with the women who I spoke to a facilitate our conversation to explore the topic in some depth. I assumed that these characteristics may, in some ways, allow me to be perceived as an insider to some extent, and therefore a trusted other. However, the women who participated this study differed to me in other respects. I have held this in mind in an attempt to avoid making assumptions about how they feel about and understand their experiences on the basis of how I believe I would respond should I have been in their position.

The participants and I differed in the sense that I also held an identity as someone who worked and studied within the NHS. I was curious as to whether this identity may have led me to be perceived as a person who shares values with a system in which they were detained against their will. I wondered whether this would be more present for participants who experienced being compulsorily admitted to hospital as negative, while those who experience it to have helped them in the long-term may position me as someone with supportive intentions.

I also remained curious about how this association with the NHS might interact with the setting that the interview took place in, and the power dynamic present during our conversations. I reflected on how in NHS settings, I, as an NHS worker and researcher and the person who booked and prepared the room, inherently held more power. However, I experienced these power dynamics to shift slightly when the interviews took place in participants' homes. A small but explicit example of this that comes to mind was in the moving of a chair; when in the NHS outpatient clinic, I moved a chair so that I could rest the voice recorder on it, and I simply said to the participant "I'm just going to move that chair", however when in a client's home and I required a chair for the same, my position was such that I, rightfully so, needed to request "Would it be possible for me to use a chair for the recorder?". To me, this superficially demonstrates how the type of setting interacted with power.

The interview were primarily planned to take place in EIS outpatient clinics to ensure that clinicians from the women's team were accessible during the interview in case the discussion caused any distress. However, a potential disadvantage of this was that the discussion was taking place in an environment that represented the same system which admitted them to hospital against their will; a power dynamic which may have influenced how comfortable the women might have felt about being open and honest during the interview. Having interviews in the women's homes was helpful for rebalancing the power dynamic, however this was at the cost of having an unknown person (the interviewer) asking personal question in a private space – this could have been experienced as more invasive that in the outpatient clinic environment.

I was curious about how the different settings may have shaped the conversation and how willing the participant was to disclose their experiences and opinions. While accepting that, in the context of the research, the power dynamics were going to be unbalanced, I was keen to trying to reduce the power differences as much as possible. This would provide more opportunity for me to meet the participant where they were at, be more able to join them in their telling of their experiences and get a better sense of the way in which they ascribed meaning to those experiences. In striving to achieve this, I noticed that I found the conversations more comfortable when in participants' homes; it felt as though we were on a more equal grounding. I was curious whether this was a shared experience for participants.

Another aspect of my identity that differed to the participants was that I did not have any experience of a 'severe' mental health problem or being taken to hospital against my will. I reflected on what it may be like for participants to be asked questions by someone who did not shared this commonality; I was curious as to whether I would be perceived as an intruder who was unaware of the privileged position of gaining access to their experiences and leaving with little consequence.

At the time of the interviews taking place, my clinical work was based in a medium-secure unit where the people I worked with were also, for the most part, detained against their will (albeit for different reasons). From this role I had some sense of the feelings experienced when being compulsorily admitted to hospital and remained connected with those throughout the interview. I believe this helped me to ask questions in a sensitive and gently curious manner rather than an intrusive manner. Furthermore, I learned from participants' feedback that they appreciated the opportunity to share their experiences with someone who genuinely wanted to listen. This kept me connected with the purpose and intention of this study and helped me to maintain a position of privileging the participants' stories rather than my own or any other.

Results

The aim of this study was to explore Black women's experiences of the decision for them to be compulsorily detained. Four Black women with recent experience of being compulsorily detained under the mental health act were interviewed and all interviews were analysed. Five superordinate themes that were identified within the analysis. All participants contributed to the superordinate themes, while their contribution to each of the subordinate themes varied, as illustrated in Table 2.

Table 2: Superordinate and subordinate themes following interpretative phenomenological analysis and their representation across participants

	Superordinate themes	Subordinate themes
During the process of being detained	Feeling vulnerable	An empty and confusing memory $^{1, 2, 4}$
		Lack of transparency and explanation $^{2, 3, 4}$
		Feeling under threat, in need of protection$^{2, 3, 4}$
	Why did this happen to me? Why was I sectioned?	Adversity and ongoing stressful life events $^{1, 2, 3, 4}$
		Aware of how my actions/behaviours seen by others$^{1, 2, 3, 4}$

During the involuntary hospital admission	A uncontaining, unsafe, and under-resourced environment	Feeling uncared for[2, 3, 4]
		Hospitalisation: “It will do more damage” [2, 3, 4]
	Pulling through: internal journey	Coming to terms with being involuntarily in hospital[2, 3, 4]
		Starting to feel myself again[1, 2, 3]
	Pulled through by relationships	Valuable, caring relationships with nurses[1, 2, 4]
		Peers helping each other out[2, 3, 4]
Theme endorsed by Patricia[1], Olivia[2], Mary[3], Sharon[4]		

During the process of being detained

Feeling vulnerable

This theme captures the powerlessness that the women described at the time that they were detained. It encompasses three subthemes that explore the experience of being in a state of confusion while feeling defenceless and in need of support.

An empty and confusing memory

Being sectioned was a bewildering experience for all four women for different reasons. Patricia and Sharon have a shared experience of not being able to recall the period immediate leading up to them being detained. As a result of this, their narratives of the events precipitating the sectioning are reliant on what they have been told by others. This not-knowing left the women feeling dejected about the time during which their capacity to process and encode memories was disrupted. Patricia felt worried that she didn’t know what had happened or how she came to be in the hospital.

> Yeah [healthcare professionals found me] on the road at night. I didn’t know nothing so after they told me yeah…I can’t remember nothing, but they say they found me in the road at night time about 3am or 2am… I asked them [what had happened] so I was little bit sad and concerned, y’know cus I didn’t know what happened. (Patricia)

Patricia understood her absence of memory being associated with having a mental health problem, saying “I was sick so I need help”. Similarly, Olivia explained that her ability to process information was also disrupted, which meant that she found it difficult to recall the details of conversations that were had and to understand the decisions that were made. Like Patricia, she conceptualised this as being associated with having a mental health problem.

> At the time I was very confused and I was weary, I wasn’t thinking straight so, and I wasn’t eating as well so I was hallucinating so I wasn’t taking anything seriously so I’d say that it was kind of like as if someone’s just telling me that “you’re going to prison for 28 days”. (Olivia)

Although Olivia was not able to fully comprehend what was happening to her, she could sense that something was wrong and that she was going to a place where she would be not be able to leave again. It seems that her interpretation was that this was a form of punishment as a opposed an opportunity for her to be looked after and kept safe; at the time she could not make sense of it. She said, “I thought like everyone was playing a prank on me, like I was sent to like some, it sounds stupid but like an undercover like police st…not police station, like prison”. The confusion also made it difficult for her to form trusting relationships with staff.

Sharon also described that the experience was so shocking and confusing that she was not able to recall what was happening at the time. Her narrative of the experience is quite fragmented because of this, however the ‘daunting’ feeling that she had at the time has stayed at the forefront for her.

> [the sectioning process is] also quite daunting y’know you see loads of people watching you, it’s like ‘what is going on?’ sort of thing. And they asked me sort of various questions, I can’t remember all of it because I was a bit shocked and alarmed really and erm then the next thing, they left and then they came back again, cus I was asleep, woke up, and said right y’know section her. (Sharon)

Sharon understood her experience of memory loss to be an adaptive and protective function during a difficult time; as though remembering what was happening at the time would be too painful to bear.

> I think I just wiped it all out to be honest with you, I think just my brain just literally wiped it out because it’s quite embarrassing, y ‘know sort of thing, so I just wiped it all out. (Sharon)

Lack of transparency and explanation

Even though the women felt vulnerable and unable to make sense of what all that was happening at the time, they also articulated a sense that professionals were not taking the time to help them understand or process what was happening during the sectioning. The process of being sectioned can be abrupt, unexpected and fast-paced, making it difficult for the person to be able to make sense of what is happening and why. The women felt as though they had been left in the dark about the sectioning process; that time was not taken to explain why they were sectioned, and the purpose of their forced inpatient admission was not clear. Mary described that the possibility of being compulsorily detained was not made clear to her in her previous contacts with mental health services.

> So the only thing I was told was come to mental health and I went to mental health, and I saw the nurse, and the nurse told me fine, can you see a doctor, I said yes I can but at the moment I'm a bit busy, because I was just filling in some forms for a job, so I told them I'm busy, but they came home and followed me, and I told them that I'm not yet free, I'm busy, I'm in the library…and the next thing is they came, they came on the [date] that you have been sectioned. (Mary)

So, due to the lack of understanding of the way in which her engagement with mental health services could escalate to her being detained, Mary reported being in a state of utter shock and confusion when people came to the house to section her. From her perspective, she was simply prioritising trying to find employment rather than visiting the doctor.

> "You are going to hospital, you've been sectioned." I told them "no, I don't know what you're talking about, what's the problem, what is this all about

> mental health?” I said “you called me to go and see the nurse at the mental health, and I went there, so what’s the problem now? Eh?... They didn’t explain! They didn’t explain anything, they didn’t. All they said was “you are under…you are being sectioned.” (Mary)

It seems as though the priorities of the healthcare professionals involved in the decision-making process (i.e. for Mary to attend and appointment with a doctor) were not aligned with Mary’s priorities (i.e. to complete paperwork to seek employment). Sharon also shared similar experiences of not receiving a thorough explanation of how the sectioning came about and what it’s purpose and intentions are.

> No one ever explained what happened… No one sort of told me, so I wasn’t told why or what. Just that you were drunk and disorderly, that’s what I was told, I mean no one told me anything about what it meant or what was going on, and I was like ‘ok’, y’know, that was it. (Sharon)

Sharon found this disconcerting, to say the least, but also felt powerless to do anything about it. Not having a sufficient understanding of what was happening affected the way in which other parts of the detention process were experienced. Sharon explained that the “not knowing” led being observed by healthcare professionals to feel particularly invasive and uncomfortable, equating it to feeling as though she was being studied rather than cared for.

> …it’s a horrible situation not knowing what’s going on. Do you know what I mean, not knowing your diagnosis, not knowing what is this? I’m quite a private person, I’m quite private do you know what I mean, so people analysing me as well, I hate it, but I don’t know what they’re reading, or what they’re putting down in the notes – it’s so like you’re this sort of experiment. Ok so, had I have known a bit more about it, maybe that might not have happened. (Sharon)

Gaining insight into the process of sectioning often involved family, friends and peers sharing information from their personal experience as opposed to healthcare professionals providing further details post-event. Olivia explained that key information and understanding eventually came after speaking to patients towards the end of the time of her involuntary admission. Once she understood the situation more clearly, then things began to feel much more manageable for her.

> I was hearing so many times in [2nd hospital] and [1st hospital] that “oh you’re on section, you can’t leave” like I didn’t know what that meant, so yeah the patients [in 3rd hospital] would explain to me what’s going on. I found from then I was like ok, I can work around this like I started attending group meetings, doing activities and all that, so it was good. (Olivia)

Similarly, Sharon’s parents had some understanding of the process; her mother attended psychoeducational carer groups provided by mental health services where she was given information that Sharon was never given directly. Through speaking with her parents, Sharon found out what had happened, what diagnosis she had been given, and what the treatment should be. While this was helpful, it did not necessarily address all of Sharon's questions while she was detained or sufficiently manage her expectations about what being detained would be like. Sharon had expected this information to come from the healthcare professionals.

> Well, it's horrible. Yeah, can you imagine, try and put yourself in my shoes, it's very daunting and like, 'what is going on?' I think my dad explained to me a bit more about it, but again it never came from [healthcare professionals], it came from other people. Patients or family members might say this is why or whatever like that, y'know, and I thought I'd be there for about two weeks and it went on for a lot longer. (Sharon)

Both Olivia and Sharon's narratives illustrate the value of sharing lived experience amongst peers. Being able to make better sense of the situation facilitated the women to be able to navigate their way through it with less distress.

Feeling under threat, in need of protection

For most of the women, the process of being sectioned and detained was scary and overwhelming. In addition to not understanding what was happening and why, they described feeling powerless and misunderstood. Mary described that she was detained at her home early in the morning by eight people, including paramedics, support workers, nurses and doctors in addition to two police officers.

> Early in the morning when I was sleeping they just knocked on the door… I got up and put on my nightdress, that was all, and I went to answer the door,

> and I saw 8 people coming in. They just stormed in the house and said you are sectioned under mental health act…when I go in the toilet, they're following me, when I go in the bedroom, they follow me, I told them give me privacy, I told them "give me privacy, let me try and just put on something on my body please", then they were just standing there, they couldn't even allow me to close the door. (Mary)

The language that she used to describe this experience paints a picture of how overpowered, vulnerable, exposed and invaded she felt during that time. While the sectioning itself was a shock, Mary was also taken aback by the way in which she was spoken to and treated, with her right to privacy and dignity taken away from her. She likened this to being a criminal.

> It's like I'm immigration, they came in like they were immigration eh? They came in like somebody is a thief or somebody has stolen something. (Mary)

Mary was surprised that someone could be treated this way without having committed a crime. Most of the women described a similar sense of shock about the way in which they were treated their distressing experiences during the sectioning process. Sharon talked about being held in a cell overnight at a local police station prior to being admitted to hospital. She described how overwhelming and uncomfortable that felt for her.

> …when inside a cell, you're gonna get a bit…delirious, and I was shouting 'get me out of here' so I was going a bit…obviously I think anyone in that

> position would go a bit mad anyway…cus it's out of your comfort zone…it was a lot of stress at the time." (Sharon)

Feeling overpowered, vulnerable and confused about what was happening, in addition to any pre-existing feelings of psychosis-relate paranoia, led some of the women to feel as though they needed help from other people to manage the situation. Being sectioned seemed to activate the basic instinct of seeking support and protection. As Mary's privacy was violated and she felt that she was not being listened to and mistreated, she requested help from her neighbours. She said:

> I went to the window and tried to tell people who were walking outside that can you please call my neighbour there, maybe my neighbour can call somebody to come and help me…(Mary)

Why did this happen to me? Why was I sectioned?

This theme describes the process that the women undertook when making sense of how the sectioning came to be. The two subthemes portray a shared understanding of how others' interpretations of their actions contributed to the decision being made to section them. There was also a sense of self-compassion for the mental health problems and difficult life circumstances that they were experiencing at the time.

Adversity and ongoing stressful life events

When making sense of what led to them being sectioned, all women describe an accumulation of stressful experiences that had led up to the decision for them to be detained. Feelings of sadness, frustration and being overwhelmed were commonly expressed, as a result of pressures related to finances, employment and family relationships. While the nature of the stressors varied, there were core features of loss, competing demands and instability. Furthermore, these stressors each had an impact on the women’s sense of self; they noticed that they were behaving in ways that were different to their usual selves.

Sharon, Mary and Patricia all described disrupted or lost family relationships in the lead up to the day that they were sectioned. Mary described that she was managing a lot at the time that she was sectioned. She described that being apart from her children, who do not live in the UK, made her feel “very low”. She was a resourceful woman who was living in an abusive home and therefore having to constantly find short term solutions to keep herself safe.

> Well at the time, there was so much going on around me, yeah, there were some family issues as well concerned, yeah so literally I wasn’t spending most nights at my home you see… I was just/living in different areas, sometimes my friends, sometimes I would go to the airport, spend two nights there, there’s a hotel there. (Mary)

Mary was living with a lot of uncertainty while also looking for employment, and managing difficult relationships at home. She went on to describe “…there was so much abuse in that home. There was so much abuse in that home.” The repetition in her description placed emphasis on the impact that living under threat was having on her at the time, enhancing how much of a desperate situation it was. Mary was functioning in survival-mode, focused on being safe.

Sharon was also under immense pressure to secure income to support herself with little help from others, while also supporting her mother. In the extract below, Sharon acknowledged that things were feeling overwhelming prior to being sectioned, although it seems that with hindsight she was able to have some self-compassion for the circumstances that she was in.

> I wanted to buy a flat but [my mom] didn't want to go for it at the last minute and it's a bit…bit crazy, plus I was working on a new collection as well, preparing for a fashion show, and stuff like that, so I have a lot of stuff to deal with…(Sharon)

There was a sense that having a lot to manage combined with difficult family dynamics was the perfect concoction for things to be difficult to cope with.

> I think [my mom] actually found it quite stressful and was taking it out on me a little bit, so we had a bit of a problem there, as a relationship, which we've never had before, ever, we're very close. (Sharon)

Patricia had been sectioned on two separate occasions, the first following the death of her twin brother and the second of her mother. She talked about these deaths having a large impact on her wellbeing, described herself as being "very sad yeah, very very sad". She also noticed changes in herself and her behaviour, saying that "since I lost my mum I was not the same…I was very…I was different". Her children also noticed these changes.

> …I was locked on my bed, yeah, I didn't like to see people, I was on my..my own, so like all the joy gone. So, I didn't call people or accept them to call me so I was like lonely. Yeah I was very sad yeah… [my children] were encouraging "mum you have to go out, you have to be the way you used to be". (Patricia)

The accumulation of these stressors created a heavy load for Patricia and the other women to carry, to the point that their sense of self was affected. Similarly to Patricia, Olivia noticed that, after an unsuccessful job interview, she was behaving in ways that she and those around her considered unusual. She said, "ever since I didn't pass my drug test at a job interview like I just started acting strange and saying weird things that didn't make sense".

Aware of how my actions/behaviours seen by others

The women both described and rated (see Figure 2) that their actions or behaviours were the main reason for them being sectioned. For some this felt justified and they somewhat agreed with the decision, while for others, it felt as though being detained was an unnecessary overreaction to difficult circumstances that they had found themselves in.

Olivia described that her family members noticed changes in her behaviour, however they played an additional role in facilitating the mental health service involvement.

> [My brother and mother noticed] that I was just wasn't myself, I was like a whole different person basically, but not in the best way. And they said that I need help so they called up the crisis team and got me help. (Olivia)

Patricia and Olivia identified that they were sectioned so that healthcare professionals could manage their behaviour. They understood their behaviour as putting themselves (Patricia) and others (Olivia) at risk of harm, as a result of having a mental health illness. For these women, the decision to section them was based on concrete and reasonable decisions about safety, regardless of whether they agreed with the sectioning at the time. When speaking to Olivia, she shared her understanding.

> I think it was a mental health problem with me because a lot of the time when doctors were telling me that it's a hospital I just wouldn't believe it and I would just believe whatever I was thinking in my head, and I was trying to attack staff when I was there because I just wasn't believing anything. (Olivia)

Sharon and Mary also understood the decision for them to be sectioned as a resulting from their actions, however they felt that healthcare professionals had misinterpreted their behaviours as being reflective of mental health problems. Sharon explained that one way that she manages stress is to use humour to de-escalate a situation, however she believed that comments she made with the intention of it being a joke were misperceived and contributed to the sectioning decision.

> I did say some silly things, it just happens I've got a bit of a funny sense of humour as well, y'know, and I just said "I'm gonna get out of here, go to Atlanta, hire a private jet and probably take my cat with me". It was a joke, I wasn't being serious I just thought…that's what I do, I think it's kind of like a defence thing I do, I try to make humour out of something. It was getting a bit too like what's going on, I thought they took that too seriously and thought 'oh she's really really crazy' and 'let's section her'. (Sharon)

Both Mary and Sharon shared that their comments and behaviours had been taken out of the context that they needed for others to understand them as reasonable reactions to overwhelming and challenging situations. This left the women feeling misunderstood and unable to agree with the sectioning being a helpful decision. Mary shared that she had been feeling frustrated by the people that she lived with teasing her and had reacted to this. She identified that the reason why healthcare professionals had decided that she needed to be compulsorily detained was because of "[her] temper".

> I have been away from my kids ok which I'm not happy at all, you see and I just try to contain it to myself you see but I don't expect somebody to be teasing me or making it like 'oh it's like she wanted to do it', or blaming me for it or anything. Obviously I would get upset, I would definitely get upset and I would tell them "don't play, don't talk to me like that", you see. You're going to force me to do something to you so don't talk to me like that, you should leave me alone. (Mary)

Mary was able to make sense of her behaviour within the context of being teased by those around her, to the extent that she felt that she had no option to react. Sharon also found herself making sense of her behaviour in the context of what was going on for her prior to sectioning. She was initially detained because she was trying to 'heal' others in a public space. Despite understanding, to some extent, why she might have behaved in that way, Sharon felt 'embarrassed' about what happened and perceived the incident as being 'bonkers really'.

> It wasn't anything like, I didn't do anything disgusting like obviously, just being like some sort of Jesus healer, I don't know, healing…maybe I was just so stressed out myself that I needed a healer, I just I don't know and I wanted to heal other people, I don't know what I was doing, y'know. (Sharon)

Area II: Experience of involuntary admission

An uncontaining, unsafe, and under-resourced environment

Once in hospital most of the women described instances when they felt uncared for by staff, and highlighted characteristics of hospital being an unpleasant environment. Although they recognised the limitations and pressures under which the staff were working, the women reflected on the importance of prioritising compassionate care to make inpatient stays a humane experience.

Feeling uncared for

Three of the women explained that they did not feel valued by the staff at the hospital. More specifically the women felt that the staff could have been more attentive to their needs and focused more on building relationships through good communication.

Not being listened to was a shared experience across three of the women and they felt that their individual needs were not valued by the nursing staff. This was further compounded by the wards not being tailored to the women's specific needs, but being occupied by people with varying degrees of severity and risk. This impersonal approach contributed to the hostile environment that the women described the hospital to be; Sharon, Mary and Olivia all described feeling as though they had gone to prison. For Sharon, it was the lack of personal interest that felt particularly punishing. She said, "it just felt like I was just like another figure, another number. Y'know, and that was a bit 'ooh', y'know. It felt like a prison". Olivia described that the lack of freedom made "you feel like you're in a prison"

Olivia described that "[she did not] feel like [hospital staff] were like helping people who don't understand" and found it difficult to having a trusting relationship with staff because she "felt like a lot of the staff wasn't being genuine". She acknowledged that part of this was linked to experiences associated with have a mental health problem, such as paranoid thoughts and hallucinations. She explained how being unable to trust staff while also not having a good understanding of what was happening when she was sectioned affected the way in which she behaved towards the nursing team.

> I wasn't like verbally abusive like I was just a bit like confrontational if someone would look at me like for too long and I'd just be like "What is the problem?" so yeah from doing that I still tried to abuse staff when I was there because I still wasn't understanding what was going on, I thought like they

> were feeding me drugs just to like forget my day or something and then I started like started drawing on their chairs saying “don’t stay overnight” cus I thought like they were just gonna keep on tricking children to keep coming here like it’s not a good place, I don’t want people to come here and I was just believing whatever I was thinking in my head. (Olivia)

While expressing her fear and frustration at being detained, Olivia did not feel safe in the hospital and felt the need to warn and try to protect other young people from being in the same situation as her. She felt as though she was being harmed as opposed to cared for, and this also influenced how able the she was to openly share her experiences with the nursing team. She explained that “I was hallucinating from when I left the first hospital and I don’t think I got that problem resolved until I went to [Hospital 3] and I told them this is what’s going on. So yeah, no one had a clue.” She wanted to stay close to her parents. She remembered thinking “my parents are going, I’m going with them” and finding it challenging to be apart from them, wanting them to accompany her when speaking with healthcare professionals.

Sharon also felt as though the staff did not prioritise gaining a full understanding of what was happening for her when she was in hospital. For Sharon, it was the lack of understanding the process and feeling as though she was left to find her way through it herself that made her want more support.

> I just thought like this is like “mommy daddy come and get me!”, “how long am I gonna be here for? What is this?” y’know and erm, so it was quite difficult y’know. (Sharon)

She explained that assumptions were made about the difficulties that she was having rather than asking her about her own. When she tried to express her opinion she described being “kind of hushed down. Like ‘yeah yeah, ok’”. She believed that without an understanding of her perspective and her experiences, staff were not able to provide her with the care that she needed.

> …they’d worked out in their mind what I’ve got, and that’s it. Then they work out their way of doing it instead of why, the reason why, listening to my stresses the property, the this, the that, the that, please understand what I’m going through /it’s very important to listen to that person’s point of view and what’s going on in order to be able to help them. What’s the root cause? Why is she acting this way? Not just think she’s got bipolar and that’s it. What leads to bipolar?/ …it’s very important to know what that actual issue is to work with that patient, and it wasn’t happening. (Sharon)

The women expressed that being treated with hostility was “unprofessional” (Olivia) and “flawed” (Sharon). Sharon and Mary had shared experiences of not feeling welcomed or respected when in hospital because of the language and tone in which they were spoken to by the staff. Sharon described that something she does remember well was the hospital environment feeling “quite hostile”.

> it’s very kind of dictorial, it wasn’t like a welcome, I wouldn’t say like be welcoming but obviously people are vulnerable, this is a very odd situation. Erm, so they seemed a bit dictorial. You know, “put this here, do this there,

> we eat here, we do…", y'know it wasn't very kind of sort of like…welcoming or cus obviously you gotta understand that this is not what I'm used to. But it seemed they were very kind of harsh. (Sharon)

Sharon noticed a lack of empathy towards her and experienced the nursing staff as being unable to understand her position as a person who was new to that environment and way of living. She noted "it felt very prison like at the beginning/mental illness is not like you're a criminal". Similarly, Mary explained that the way in which she was spoken to felt as though she was being criminalised.

> they're supposed to respect your dignity as well, yeah but sometimes they just come and push you, get out of that toilet, yes!/ They should show that respect by speaking to you properly, not speak to you like a criminal. You are not a criminal. (Mary)

In considering the ways in which each of the women felt as though their care was substandard and punitive, they acknowledged the role of the system in the limited quality of care provision. It is a common narrative that the NHS is overworked and under-resourced and this is something that the women considered as impacting on the way in which nursing staff treated them.

> I think everyone has good intentions but I think the system fails it. There's either not enough staff or there's not y'know the systems not quite right y'know, to make people do what they really want to do. (Sharon)

Sharon and Mary understood the healthcare teams' behaviour in the context of the systems in which they were functioning, believing that the staff's upsetting behaviour was not intentional but inexcusable. Mary said, "we do understand it's a stressful job, that I can't lie, I'll say it is a stressful job but I mean they're supposed to at least follow good guidelines". The system was perceived as being inflexible and inaccessible so the women felt they did not have the power to improve things.

> You see, I can't come in and tell them you need to change your system, that's their system, that's the way they do it…you can appeal if you want but I mean if people who take you like that, is there any chance of even appealing, that's a waste of time. (Mary)

Hospitalisation: It can do more damage

All women identified ways in which had a negative impact on their wellbeing, particularly in relation to lowering their mood. Being in the same environment for a long period of time with restricted freedom, little activity and peers who were also in crisis was disheartening for most of the women; they simply did not want to be there. Sharon stated, "you can't be there for too long, it'll kind of, you'll do more damage".

Mary noticed the impact of being sectioned on her mood. She said "I mean I became depressed a bit, yeah! Me being there it really really brought me so low, I was just feeling so low" and summarised the experience as "the worst worst experience ever ever in my life." The was a particularly strong statement given her description of trying to escape abuse at home.

Olivia reported a similar experience of her wellbeing deteriorating while being in hospital and this was something that her family noticed too.

> I was just depressed, I was looking worse and worse every time, I was just there, alive basically, I was just going mad in there/When my parents would come and see me like I look worse and worse every time. And I would tell them it's like hell laying here but like there's nothing they could do so that was that. (Olivia)

All women named that being with other patients who were experiencing more severe mental health crises had a negative impact on them. Being exposed to other people's difficulties in such extensive proximity was overwhelming, intense and had a lasting impact. Sharon described, "I've seen some stuff in there that I've never seen before". Mary strongly felt that women should be differentiated according to their presentation because of the way in which being around people who were more unwell was harmful for those who were more stable.

> you know they put you all together because every patient is on a certain level, so they put you all like altogether you see, which we complained even with other patients in there, we complained that no they should differentiate, right? There are some who are really quite bad and some who are ok, they're thinking but if you come and put all of them in one you are going to…to…I mean the others are going to be worse. Eh? Or they'll be just like the others who they found there. (Mary)

Pulling through: internal journey

This theme encompasses the inner processes and internal resources of strength and resilience that the women drew on to cope with the experience of being in hospital within the context of compulsory admission. The two subthemes describe the women re-connecting with their sense of self after reaching a point of acceptance/resignation about being detained in hospital.

Coming to terms with it all

Most of the women described that at some point throughout the time that they were sectioned, they managed to find resolve and began to come to terms with being hospitalised. It was at this point that the women described they were able to focus on how they could get themselves released from the section and regain their freedom.

> You kind of wake up and you see this is reality now, this is what’s going on, and how long will I be here for, I don’t know. But I just wanted to leave really. I just wanted to get out and go home. (Sharon)

By somewhat accepting the situation and telling herself “it is what it is” Sharon was able to adjust her frame of mind to actively work towards getting discharged from hospital. She knew that prioritising her own wellbeing was key and deduced that compliance would be the easiest way to achieve this; following the path of least resistance. Drawing on her own identity as a strong, adaptable woman was important to help Sharon adjust to the new environment and manage being detained.

> I'm quite a strong person so I thought I can't, ok, I can't go crazy here, just stick to what they're telling me to do but it did feel very daunting. But I'm quite an adaptable person to people and things like that so I just thought ok, it is what it is, I can't, I just have to go for it really. (Sharon)

Mary was inspired by her family to also connect with her inner strength. She said, "I had to fight my way up, I have got children I have to be strong".

Coming to terms with being sectioned was not as smooth a process for all women though. Olivia described that she found it harder to come to terms with the involuntary hospitalisation because she placed the blame on herself for being sectioned.

> I was just thinking "how did I do this to myself?" like "I shouldn't have ever called the ambulance" like "now I have to stay here" I was just…I wasn't like believing that I had to stay there for a good like week, that's why I was just like just trying to fight everyone like just to go home. But yeah when they told me that then it hit me like I have to stay and I hated it. (Olivia)

When she did start to understand the extent of the situation and realised the negative consequences of being aggressive towards staff, she made a conscious effort to become more submissive and compliant.

> Umm from [Hospital 1], and they told me I'd be transferred to [Hospital 2], that's when it like really kicked in and they said that if I continued then I'm just gonna keep on getting transferred even further away so I just…like that

> sunk in and I was just thinking like "I need to survive, I need to just be on my best behaviour or something". (Olivia)

Finding inner peace through faith was helpful for some women. While Mary disagreed with the decision to be sectioned she did not attempt to 'fight back' partly because she did not believe that it would be successful, but also because she placed her trust in her faith and found strength in her family relationships pulling her through the difficult time.

> Well of course they did misunderstand my situation but…I had no powers. They had more powers than me so there's nothing that I could do, I just had to give in./Oh I can't do anything! I just let them. I just let them, from my Christian spiritual point of view, I told them "let them do what they want"/God will go before me, that's why I just reached that point. (Mary)

Olivia shared that her faith allowed her to share what was going on for her mentally and emotionally at time when she felt she could not open up to the people around her. Olivia said, "I wouldn't really share my thoughts with people but like I would always pray to myself in my head and like say little prayers when I was feeling low in that place, so that helped".

Starting to feel myself again

Three of the women found acknowledged that the time spent in compulsory detention was helpful in some ways, be it practically and or psychologically. Mary valued the practical assistance; she was sleeping better on a different medication and felt “lucky” that the service sourced her a new accommodation away from the abuse that she was previously experiencing. Having time away from the chaotic and isolative situations that they were in prior to sectioning helped them to reconnect with their identity and to starting feel more like themselves again. Patricia and Olivia both noticed that by the time they were leaving the hospital, they were living more in line with their personal values and were on a more progressive path.

Patricia spoke with a large smile and a sense of pride when describing how different she felt when she was leaving hospital compared to when she was admitted. Patricia’s experience of being sectioned was particularly transformative and she left hospital feeling as though she was more like her ‘old’ self, the self that her children had encouraged her to be when she was unwell. She felt particularly validated when the nursing team celebrated her progress with her.

> Yeah I’ve changed a lot. If you see me I was…even the day I was coming from hospital they was like “wow!”/They say “you are different, you are like old woman” so then when they told me “you are going home” they call taxi so I get dressed, I put everything, makeup, everything, they said “it’s not you” I said “it’s me!”. (Patricia)

Despite not agreeing with the decision to section her, Olivia also acknowledged that she was able to reconnect with her identity and get herself back on track. While for Patricia the experience was restorative, Olivia’s experience was that it was more rehabilitative. Olivia shared that she had been engaging behaviours which no longer felt helpful, including regularly taking illicit drugs and drinking alcohol. She shared that being detained supported her to change this lifestyle. Olivia found the hospitalisation to be a source of growth for her, and she felt more resilient because of it.

> I'm so used to having what I want really at home and so when I had all of those things taken away like it taught me to be like more like…I wouldn't say…ok like down to earth but like more aware of like social situations because before I was like, I admit I was like an alcoholic and then when I went there for 28 days it's like rehab kind of so it changed my behaviour a lot, I'd say for the best and like anything that I went through that was too hard like, I've just come out stronger. (Olivia)

Pulled through by relationships

This theme captures the women's experiences of relationships with other people during the hospital admission. They discuss the ups and downs that came with these relationships, with an overall sense that connecting with others reignited their sense of joy and humanity in the process.

Valuable, caring relationships with nurses

In spite of reporting that there were experiences of mistreatment (in theme 'An uncontaining, unsafe environment), most of the women also identified that positive relationships with health care professionals improved their experience of being compulsorily detained. Although the relationships took time to develop, they helped the women to feel 'seen' as human beings rather than just numbers passing through the system. The women valued being listened to by staff and sharing their interests. Connecting on a more personal level helped to build trust and improved engagement.

Olivia had been in three different hospitals during the time that she was sectioned. She started to have a more positive experience when she was in the third hospital because staff were more welcoming and approachable.

> Olivia: I got transferred to [Hospital 3] and I was a lot better there, but the previous two hospitals, it was like a nightmare for me.
>
> Interviewer: Really? What was the differ…what made the difference at [Hospital 3]?
>
> Olivia: Um, I think that the staff were a lot friendlier and the people, because it’s closer to home like I felt more trusting of the place, and yeah it’s just better treatment there

This was fundamental to her experience of being in hospital improving as she was able to communicate her needs rather than keep them to herself and by having more information, she felt that staff were able to respond in a meaningfully. Being able to trust and being more open enabled professionals to respond to the women’s needs.

> Like occupational therapy staff that were like there to talk to if you had any problems so like I did have a few problems and I talked to them and it was very helpful, like they showed me like how much help I could get outside of being in the hospital, and like different websites that I can go on for like support, so it was good. (Olivia)

Being able to provide this personalised and responsive care that met the needs of the women stood out as being particularly helpful. Patricia had a described a wholly positive experience of being in hospital because she found the staff to be thoughtful and considerate of the time she took to adjust to the setting and the physical health problems that she presented with. She reflected on how the nursing staff were patient with her when she did not feel able to speak and listened intently when she chose to talk more. She described "at beginning it was hard cus I didn't like to talk, I was locked on my bed. They was so patient to me, very very careful and very patient".

Patricia valued the kindness and care that she was shown by the nurses and believed that this was fundamental to her recovery. She said, "the love will heal me/it was my first time you know, to feel that love".

Forming a meaningful connection with healthcare professional by engaging in shared activities helped the staff-patient dynamic evolve into a more supportive relationship.

> I mean the nurses, I mean I'm, I'm quite a fun person I believe, and I love dancing, things like that y'know, I was a dancer for 15 years, and erm being creative you're a bit wacky anyway, so I'd try and bring out that in people. So with the nurses, they at some point got to quite like me, a lot of them are African in there, it was all African women in there, I don't know what that's about but I'd do a dance with them and things like that, so they made it a bit easier. (Sharon)

Sharon valued the opportunity to express herself whilst on the ward and found opening up in this way facilitated her forming mutual relationships with the nursing team. She believed that shared ethnicity was beneficial in this forming these relationships, saying "I'm Black anyway so I relate to these people". She was aware that these connections around shared ethnicity were in relation to staff who were in less senior positions saying, "the nurses all seem to be Black and then say doctors are white".

Peers helping each other out

While at times being in the same environment as peers with more severe mental health problems was an additional stressor for the women, the peer relationships were also highly informative and supportive. In addition to providing more first-hand guidance on what it means to be sectioned, patients on the ward could offer reassurance, companionship and provide a sense of purpose when they asked for support from the women.

Mary described that being around other people on the ward was a validating experience because they normalised what had happened and shared the discomfort of being detained.

> You meet other people and they explain oh my situation was like this, this is what they did to me/…at times when we were seated quiet in the lounge and we are listening to TV, we're watching TV, we're listening to music. Yeah, and then sometimes we just started chatting, yeah. And obviously everyone is there to listen to each other's problems, to encourage ourselves. (Mary)

By all being in similar situations, the other people detained on the ward were able to offer genuine empathy and compassion for the difficult situation. There was comfort in being with other. At times, the other people helped the women to develop a supporting role on the ward, although it's not clear whether these roles were wanted. Mary described a time that she helped someone to calm down when they were feeling suicidal. Despite not having experience working in mental health setting, Mary was able to respond in a compassionate way by connecting with her peer's struggle with understanding and taking simple steps to offer comfort.

> In the end you ended up helping them cus they would obviously come to you and start crying, oh I want to kill myself, I feel like harming myself, so what do you do? You just calm them down, comfort them, no ok we are all in the same boat, just calm down. If you're not feeling like, just take a nap and you'll be ok. Yeah. (Mary)

Sharon also found herself offering a supporting role to peers while in hospital. She had previous experience mentoring and named the importance of listening to people in order to be able to help them, however, was also taken aback by the intensity of the problems that her peers were presenting with. Although she did offer support to peers, it was an overwhelming experience.

> Like you've got suicidal people in there that completely want to kill themselves, they've got nothing to live for. I got to the point where I actually started mentoring them! [laughs] Yeah, I was mentoring them like why do

> you…you've got everything…I dunno, it's just like I've seen people like y'know…I'm like Woah! (Sharon)

While Sharon could connect with the helping role, she enjoyed having the opportunity to use her creativity skills to help be an "indirect mentor" to others too. She talked about starting a painting activity where others joined in as being something that helped her while she was detained. Expression and personal connection were key.

Post-interview ratings of factors influenced the decision to detain

After the interview, women were asked to rate how much they believed various factors influenced the decision for them to be sectioned. As illustrated in Figure 2, risk, mental health and attempt to offer care were viewed by all the women as core to the decision to section them. Patricia, Olivia and Sharon believed that ethnicity played did not contribute at all, whereas Mary believed that the personal characteristics of education level, social class, religion, ethnicity and gender were all substantial contributing factors.

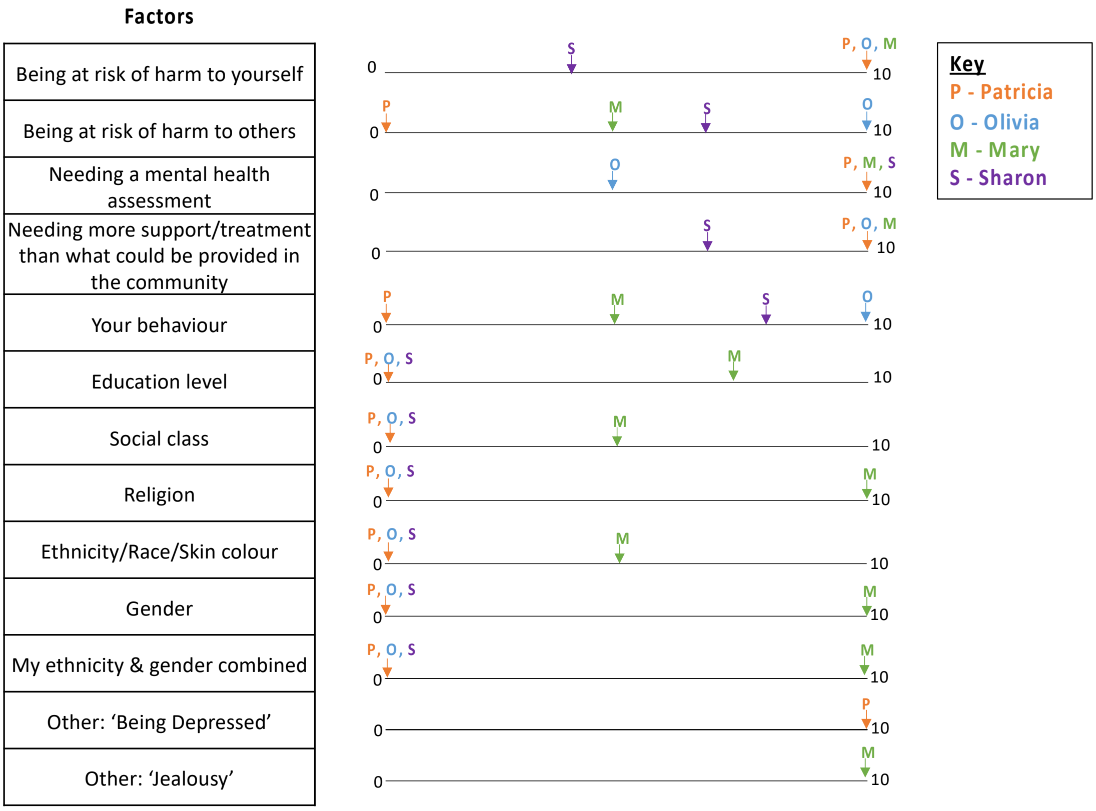


Figure 2: Participants ratings of how much they believed each factor influence the decision for them to be sectioned.

Discussion

In the UK, Black people are significantly more likely to be compulsorily detained that their white British counterparts, with the disparity being up to 7 times greater for Black African women (Mann et al., 2014). There is little insight into the experiences of the women who have been sectioned, therefore this qualitative study aimed to shed light on their perspectives of the sectioning process. Specifically, the study explored Black women's experiences of the decision for them to be sectioned and the factors that they felt influenced the decision using semi-structured interviews. Participants spoke in detail about the traumatic and distressing aspects of the sectioning process, the importance of meaningful relationships when hospitalised in an under-resourced, overworked system, and the way in which they felt it was their behaviour, as opposed to personal characteristics, that influenced the decision for them to be sectioned.

The traumatic and distressing experience of being sectioned

The women who participated in this study described feeling distressed and vulnerable throughout the process of being sectioned. For most women, their cognitive capacity at the time of sectioning was compromised as a result of either substance use, symptoms associated with psychosis, or both. This made it difficult to comprehend what was happening both during and after the time that they were sectioned. This experience is not unique to the women that were interviewed; previous literature has demonstrated that the experience of being involuntarily admitted to hospital is distressing and can lead to psychosis-related PTSD (Berry et al., 2013; Berry et al., 2015; Rodrigues & Anderson, 2017). Distressing and disempowering experiences during involuntary hospitalisation have a negative impact on how individuals perceive themselves and are associated with increased incidents of conflict with staff (Hughes 2009).

The women felt as though there was a lack of transparency about and explanation of the sectioning process. Women described feeling confused and not being able to make sense of the situation until later into their admission. For some women this was frustrating. However, given that some women's memory processing was disrupted by perturbed cognitive function, it is not clear whether healthcare professionals did not provide an explanation or whether the level of distress at the time of sectioning led the information to not be processed in an effective manner. Nonetheless, during times when women were unable to recall what happened, their recollection of the emotions associated with the sectioning remained intact.

The process of compulsory detention is not only an afflicting situation for the person being detained, but also for the professionals conducting the detention. Professionals have reported to find the experience to be fear provoking in various ways; they recognise that both detaining and not detaining an individual may lead to harmful consequences for the patients, while also fearing the personal and professional consequences of any such possible harm (Allen & McCusker, 2020). Factors such as time pressure, workload, team dynamics, case complexity, chaotic environmental factors and clinician emotional state can also affect decision-making in high-pressure, emergency situations (Zavala et al., 2018). Consequently, the professionals involved are acting within a high-pressure situation, which may make it more difficult to prioritise a person-centred, compassionate and empathetic approach to communicating information to the patient.

Reduction in blame culture can help alleviate some of the fear, taking a systemic approach to understand negative outcomes resulting from errors in decision-making, within reason of course. This has been recognised within the UK government paper, ‘Learning Not Blaming’ (Department of Health, 2016) which encourages a move away from ‘blaming’ individual healthcare professionals for medical decisions that result in negative outcome with the aim of creating a safer environment in which clinicians can be more transparent about errors they make. Continuing to champion this movement throughout teams of professionals involved in the sectioning process may relieve some of the fear and pressure that they experience during the sectioning process, making more space for person-centred interactions that may help reduce distress in patients.

Despite the pressure that clinicians face, patients feel more valued and respected when efforts are made to ensure that they are supported to understand the circumstances and oriented to the new environment in which they have been place (Wyder et al., 2015). Arguably this is particularly important in involuntary inpatient settings where patients have had their freedom taken away from them. This implies that attending to how a patient is made to feel at the time that they are sectioned may take priority over whether they are able to make sense of the information being given. Focusing attention on caring for the person in a compassionate, empathetic and caring manner could be particularly important for people who may not be able to later recall the sectioning occurring.

Should a patient's mental state place limitations on the degree to which they can comprehend and retain new information, it may be important to use strategies and techniques that facilitate effective communication rather than waiting for an individual's ability to understand to return. There is some evidence that specific training programs that focus on equipping healthcare professionals with the skills to adapt their interactional patterns when working with people with psychosis can significantly improve the quality of the therapeutic relationship for both clients and clinicians (McCabe et al., 2016).

The importance of meaningful relationships within an under-resourced system

All participants acknowledged that the relationships that they had with healthcare staff and peers influenced their experience of being compulsorily detained. When interactions with healthcare staff were experienced as hostile and the women felt as though they were not being listened to, being sectioned felt less helpful and more aversive. However, when the women felt as though healthcare staff showed them kindness, compassion and patience by offering them the time to share their concerns and address their needs, the women experienced being sectioned as helping to regain their sense of self. Good relationships with the healthcare team were highly valued by the women who experienced them.

In the inpatient context, therapeutic relationships with nursing staff increase the effectiveness of care provision, regardless of whether there is active therapeutic intervention involved in the relationship (Hughes et al., 2009; McAndrew et al., 2014). Positive nurse-patient relationships can facilitate recovery and are associated with improved outcomes (Browne et al., 2019). Patients have identified that a good quality therapeutic relations has five core qualities; (1) acceptance/respect/absence of prejudice, (2) empathy/understanding, (3) listening/accessibility/companionship, (4) authenticity/honesty/trust, (5) friendliness/sense of humour (Moreno-Poyato et al., 2016). It is clear that patients value being ‘seen’ and treated as human beings who need supporting in a vulnerable situation as opposed to being considered as another person passing through a punitive system; the women emphasised that to have a mental illness is not a crime and therefore patients should not be treated as such.

Women who spoke about being dissatisfied with the lack of meaningful interactions that they had with members of staff did acknowledge that this was not necessarily their intention, but that the staff were having to work in under-resourced conditions that limited their capacity to attend to the needs of the women. While this was understood, they still expected a better standard of care once hospitalised. Clinicians also report resource-related barriers to the development of a therapeutic relationship within the inpatient context, such as administrative tasks and short lengths of stay.

In addition to resource-related barriers to the therapeutic relationship, clinicians have identified personal factors related to the context and nature of their work (Moreno-Poyato et al., 2016). Nurses report that perceived and actual risk of being assaulted or causing harm (Ward, 2013) and feeling unable to provide the personalised care that patients need prevents nurses from interacting with patients (Hopkins et al., 2009). Furthermore, nurses acknowledged that working in an environment that endorses socially unacceptable clinical practices of coercion and control can be demotivated and unpleasant, making it more challenging to prioritise and genuinely form therapeutic relationships with patients (Shattell et al., 2008).

Without a personal relationship being formed with staff, the women interviewed in this study also found in more difficult to trust the healthcare team. Some of the women felt as though their input was not valued or seriously considered, with clinicians making assumptions about their needs based on diagnostic labels that had been ascribed. In the absence of a trusting, mutually respectful relationship, patients also found it more difficult to share the details of their experiences, therefore the healthcare team was not able to adequately meet their needs. For care to be collaborative, it is important for patients to feel as though their experiences of mental health problems will be listened to, taken seriously and involved in decisions made (Wyder et al., 2015). This could improve the degree to which patients feel as though their care is collaborative rather that coercive, increasing a sense of autonomy and supporting engagement (Theodoridou et al., 2012).

Peer relationships were highly valued by the women interviewed. Naturally occurring peer support in inpatient settings tends to unfold as a consequence of people living together in a self-contained environment (Galloway & Pistrang, 2019). Peer support can take various forms such as sharing items, providing information, offering companionship and giving sense of unity in trying to overcome the mental health difficulties that the patients are experiencing (Bouchard et al., 2010; Galloway & Pistrang, 2019). While mostly helpful, peer relations could also be distressing, particularly when the women found themselves in roles supporting other individuals at crisis points, for example managing suicidal ideation of peers. Witnessing their peers' high levels of distress sometimes felt harmful and at times it felt more important to distance themselves from others. While staff can intervene, allowing patients the space to assess their own capacity to manage peer relations can support them to maintain a sense of autonomy while allowing them to form mutually beneficial, appropriately boundaried relationships (Galloway & Pistrang, 2019)

Perspectives on factors that influenced the decision to compulsorily detain

Ethnic disparities in sectioning (NHS Digital, 2019) have been longstanding in the UK and it has been reported that racial bias may play a part in maintaining this (Department of Health and Social Care, 2019b). However evidence demonstrating the influence of racial bias on clinical decision making is limited and inconsistent. In their review, van Ryn et al. (2011) propose that white clinicians hold implicit biases that function independently of any explicit racially stereotyped attitudes they may hold. They also proposed that these racial biases can influence clinical decision making in regard to Black patients (van Ryn et al., 2011). However in a more recent review, Dehon et al. (2017) conclude that white clinicians' implicit racial preference towards white people does not appear to influence clinical decision-making, although they recognise that the quality of the two studies exploring this relationship were low.

In line with Dehon et al.'s (2017) conclusion, most of the women interviewed in this study did not believe that their ethnicity influenced the decision for them to be sectioned; they believed that the decision was made based on their behaviour at the time and that they needed more support than could be offered in the community. There may be a number of reasons for this.

Firstly, unlike explicit racist attitudes and discrimination, implicit racial biases function at a subtle level which can be difficult to detect in usual day-to-day circumstances. In the context of being sectioned, where levels of distress are high and cognitive function may be disturbed, identifying subtle racism becomes even more of a challenge. It is possible that the women interviewed were unable to detect racially biased behaviours because they were less cognitively astute at the time of sectioning. Furthermore, the women would not have been able to access concrete evidence of ethnic bias because they do not have an equivalent reference experience by which to compare the treatment received; the women cannot re-experience the sectioning process as a white woman. Interestingly Mary, the only woman to identify ethnicity and other personal characteristics as having an influence on the decision to section, was the only woman interviewed who was able to clearly remember the time that that she was detained.

Secondly, given that the women who could not recall being detained were informed about what happened by others, it is possible that their narrative of the reason why they were sectioned is a replication of the information that they were given by clinicians. It is unlikely that the clinicians would explicitly identify ethnicity as a contributing factor to the decision to detain the women. Furthermore, being sectioned to manage the risk associated with their behaviour may be experienced as a reasonably complete explanation that does not invite further critical analysis to make send. As a result, the women may have internalised the narrative that their behaviour was problematic enough to require detaining without critical analysis of other factors that may also have contributed to the decision.

Furthermore, this study took part in an ethnically diverse area of London, and this diversity was reflected in the clinicians involved in the sectioning process of the women interviewed. Having more ethnic minority representation within the staff team might have reduced the likelihood that the women would attribute being of Black ethnicity as a key contributing factor. However, one woman noticed that the most senior people in the clinical team tended to be of white ethnicity while the more junior team tended to be Black, although it is not clear how much she associated them with being the decision-makers in the system.

Ethnic health disparities exist beyond mental health, for example Black women are more than 5 times more likely to die in childbirth than white women (Knight et al., 2019). Racism in healthcare services can manifest in various forms; systemically, institutionally, interpersonally and in an internalised manner. It is only more recently in the context of stark health inequalities during the coronavirus pandemic that people are speaking about this more openly and considering the complex way in which racism may affect inequalities throughout the whole healthcare system. To be able to confidently attribute a personal experience to racism of any type requires and thorough understanding of the system and its processes and protocols. This is something that might not be considered by patients on the receiving end of care, particularly when in distress.

Clinical implications

Do what it takes to hold a compassionate position in interactions with service users

While working under pressured conditions and in distressing situations, it is important that clinicians prioritise working with service users from a position of compassion. Treating service users with respect, humanity, patience and kindness improves the therapeutic relationship and is associated with more positive outcomes. Recognising that understanding may be limited is key, and information sharing should be seen to be an ongoing process until the service user is able to retain the information (Wyder et al., 2015). To achieve this, clinicians need to be well-supported in their work.

This support may be in the form of more focused individual or peer supervision sessions focused on the decision-making process and how that decision is actioned. Furthermore, encouraging clinicians to debrief and review the process of admitting someone against their will may create more space for them to hold in mind the amount of distress that the person may be experiencing in the moment. Holding a compassionate perspective may also allow expressions of challenging behaviour to be understood and responded to in a helpful way.

Building meaningful and collaborative therapeutic relationships could alleviate pressure

Regardless of how they feel about the decision for them to be detained, service users value the relationships that they have during that distressing and potentially traumatic time. Supporting staff to have the capacity to build these relationships is important (Hughes et al., 2009). This support may be logistical, for example allocating more specific time to solely spend building relationships with service uses, or it may be involve striving for a culture-shift (see Shoreditch Ward (2019) ‘Flip The Triangle’ project as an example of how culture-shift can be achieved). Furthermore, where appropriate, sharing decision-making during treatment planning in the early stages of hospitalisation may be a helpful way to begin building a collaborative therapeutic alliance (Burn et al., 2019). Finally, supporting service users to develop peer relationships may be practically and psychological helpful and encourage engagement.

Examine racism at all levels; structural, institutional and interpersonal

Although most of the women in this study did not identify their ethnicity as influencing the decision for them to be compulsorily detained, this does not mean that racial biases and other forms of racism do not contribute to the women being sectioned. Racism is complex and deeply embedded in broader systems of social and health inequalities in the UK. A further, in depth analysis of the way in which racism influence the system and risk factors to being sectioned is needed to gain a full understanding of its role (or lack of) in ethnic disparities in compulsory detention.

Limitations

The findings of this study have limited generalisability because IPA is an idiographic approach focused on the meaning making of a small group of individuals. Furthermore, this study only included four participants within a particularly diverse region of London. Where one woman had a substantially more positive experience than the other three women, some of her experiences are not as fully represented across the subthemes. Furthermore, while we were able to communicate effectively, this woman had the most limited understanding and use of the English language, which may have further impacted the degree to which she was able to share her sense-making in a thorough enough way for it to be captured in a theme. It is possible that a greater number of participants would have led some of her experiences to have been better represented in the data.

Part of the interview involved the recollection of information at the time that participants were detained, however most women were unable to remember the details of what happened due to their cognitive function being impaired at the time. As a result of this, there was limited insight into the factors that contributed to the decision-making process and who was involved in making that decision. However, this gave a good representation of the ways in which the women were left to make their own sense of what happened based on what they were told by people around them. Nonetheless, for the purpose of this study, it may have been helpful to have access to more specific memories of the detention.

It is also important to consider that, if systemic racism is contributing to the decision for participants to be sectioned or to the ethnic disparity in sectioning, it would be difficult to assess at the level of the patient. More complex, nuanced analyses of the wider system in which the inequalities are located would need to be conducted to fully understand the role of racism in health inequalities.

Future research

In striving to explore the factors influencing the ethnic disparities in the sectioning of women in the UK, this research question can only answer half of the story; that told by the service user. Gaining the perspectives of professionals involved in the detention process is also essential for gaining further insight into the factors underlying decision-making processes. However, assessing whether ethnicity is an influential factor in decision-making might be particularly challenging; clinicians may either not be aware of the influence or feel uncomfortable sharing that information. Implicit measurements of bias may be necessary to better assess the influence from a clinician’s perspective.

Should implicit biases be found to influence the sectioning process, research exploring strategies to reduce bias in a way that influences practice can improve patient satisfaction (Zestcott et al., 2016) and may empower professionals to feel more confident in their decision-making. Embodying the experience of being a Black using virtual race transformation has shown to produce a sustained reduction in implicit racial biases (Hasler et al., 2017). Research methods like virtual reality might offer opportunities to reduce bias by allowing professionals to experience events from the perspective of the service user while being of different ethnicities (Banakou et al., 2016).

Service users may also benefit from more research about what could make the experience of being detained less distressing and traumatic and help them to feel safe and cared for rather than criminalised. An evaluation of possible interventions for reducing the impact of possible trauma could help reduce the effects of being sectioned on people’s mental health. For example, patients in a psychiatric intensive care unit have reported that a debrief following seclusion incidents would support them the make sense of the confusing experience (Allikmets et al., 2020). This research could help to improve engagement and reduce stigma around the sectioning process for both service users and clinicians. It may also reduce the degree to which clinicians find the process stressful.

References

Abdelghaffar, W., Ouali, U., Jomli, R., Zgueb, Y., & Nacef, F. (2018). Post-traumatic stress disorder in first episode psychosis: Prevalence and related factors. *Clinical Schizophrenia & related psychoses, 12*(3), 105-112B.

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open, 5*(3).

Allen, S., & McCusker, P. (2020). A Hidden Dynamic: Examining the Impact of Fear on Mental Health Officers' Decisions to Use Powers of Compulsory Detention. *Practice*, 1-15. https://doi.org/10.1080/09503153.2020.1782873

Allikmets, S., Marshall, C., Murad, O., & Gupta, K. (2020). Seclusion: A Patient Perspective. *Issues in Mental Health Nursing*, 1-13. https://doi.org/10.1080/01612840.2019.1710005

Banakou, D., Hanumanthu, P. D., & Slater, M. (2016). Virtual Embodiment of White People in a Black Virtual Body Leads to a Sustained Reduction in Their Implicit Racial Bias. *Frontiers in human neuroscience, 10,* 601-601. https://doi.org/10.3389/fnhum.2016.00601

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (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.

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis and hospitalisation: A review of the literature. *Clinical Psychology Review, 33*(4), 526-538.

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2015). Trauma in relation to psychosis and hospital experiences: The role of past trauma and attachment. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(3), 227-239.

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: systematic review. *The British Journal of Psychiatry, 182*(2), 105-116.

Blakemore, E. (2019). *Race and ethnicity: How are they different?* https://www.nationalgeographic.com/culture/topics/reference/race-ethnicity/#:~:text=%E2%80%9CRace%E2%80%9D%20is%20usually%20associated%20with,and%20characterize%20seemingly%20distinct%20populations.).

Bouchard, L., Montreuil, M., & Gros, C. (2010). Peer support among inpatients in an adult mental health setting. *Issues in Mental Health Nursing, 31*(9), 589-598.

Browne, J., Nagendra, A., Kurtz, M., Berry, K., & Penn, D. L. (2019, 2019/07/01/). The relationship between the therapeutic alliance and client variables in individual treatment for schizophrenia spectrum disorders and early psychosis: Narrative review. *Clinical Psychology Review, 71*, 51-62. https://doi.org/https://doi.org/10.1016/j.cpr.2019.05.002

Burn, E., Conneely, M., Leverton, M., & Giacco, D. (2019). Giving Patients Choices During Involuntary Admission: A New Intervention. *Front Psychiatry, 10*, 433. https://doi.org/10.3389/fpsyt.2019.00433

Burnett, R., Mallett, R., Bhugra, D., Hutchinson, G., Der, G., & Leff, J. (1999). The first contact of patients with schizophrenia with psychiatric services: social factors and pathways to care in a multi-ethnic population. *Psychological medicine, 29*(2), 475-483.

Carr, S., Hardy, A., & Fornells-Ambrojo, M. (2018). The Trauma and Life Events (TALE) checklist: development of a tool for improving routine screening in people with psychosis. *European journal of psychotraumatology, 9*(1), 1512265.

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), 50.

Cloitre, M., Shevlin, M., Brewin, C., Bisson, J. I., Roberts, N. P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica, 138*(6), 536-546.

Cole, E., Leavey, G., King, M., Johnson-Sabine, E., & Hoar, A. (1995). Pathways to care for patients with a first episode of psychosis: a comparison of ethnic groups. *The British Journal of Psychiatry, 167*(6), 770-776.

Commander, M., Cochrane, R., Sashidharan, S., Akilu, F., & Wildsmith, E. (1999). Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care. *Social psychiatry and psychiatric epidemiology, 34*(9), 484-491.

Copson, E., Maishman, T., Gerty, S., Eccles, B., Stanton, L., Cutress, R. I., Altman, D. G., Durcan, L., Simmonds, P., Jones, L., Tapper, W., Eccles, D., & group, P. s. s. (2014, 2014/01/01). Ethnicity and outcome of young breast cancer patients in the United Kingdom: the POSH study. *British Journal of Cancer, 110*(1), 230-241. https://doi.org/10.1038/bjc.2013.650

Davidsen, A. S. (2013). Phenomenological approaches in psychology and health sciences. *Qualitative research in psychology, 10*(3), 318-339.

Dehon, E., Weiss, N., Jones, J., Faulconer, W., Hinton, E., & Sterling, S. (2017, Aug). A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making. *Acad Emerg Med, 24*(8), 895-904. https://doi.org/10.1111/acem.13214

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*. http://webarchive.nationalarchives.gov.uk/20130123204153tf_/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Department of Health. (2016). *Learning Not Blaming*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445640/Learning_not_blaming_acc.pdf

Department of Health and Social Care. (2017). *Terms of reference: independent review of the Mental Health Act 1983* (The Independent Review of the Mental Health Act 1983, Issue. https://www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983

Department of Health and Social Care. (2019a). *Independent Review of the Mental Health Act 1983: Supporting documents* (The Independent Review of the Mental Health Act 1983, Issue. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

Department of Health and Social Care. (2019b). *Modernising the Mental Health Act: increasing choice, reducing compulsion* (The Independent Review of the Mental Health Act 1983, Issue. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

Fenton, K., Larkin, M., Boden, Z. V., Thompson, J., Hickman, G., & Newton, E. (2014, Nov). The experiential impact of hospitalisation in early psychosis: service-user accounts of inpatient environments. *Health Place, 30*, 234-241. https://doi.org/10.1016/j.healthplace.2014.09.013

Fornells-Ambrojo, M., Gracie, A., Brewin, C. R., & Hardy, A. (2016). Narrowing the focus on the assessment of psychosis-related PTSD: A methodologically orientated systematic review. *European journal of psychotraumatology, 7*(1), 32095.

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. P. (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.

Galloway, A., & Pistrang, N. (2019, 2019/07/04). “We’re stronger if we work together”: experiences of naturally occurring peer support in an inpatient setting. *Journal of mental Health, 28*(4), 419-426. https://doi.org/10.1080/09638237.2018.1521925

Goater, N., King, M., Cole, E., Leavey, G., Johnson-Sabine, E., Blizard, R., & Hoar, A. (1999). Ethnicity and outcome of psychosis. *The British Journal of Psychiatry, 175*(1), 34-42.

Goulden, R., Corker, E., Evans-Lacko, S., Rose, D., Thornicroft, G., & Henderson, C. (2011). Newspaper coverage of mental illness in the UK, 1992-2008. *BMC public health, 11*(1), 796.

Haarmans, M., Vass, V., & Bentall, R. P. (2016, 2016/07/02). Voices' use of gender, race and other social categories to undermine female voice-hearers: Implications for incorporating intersectionality within CBT for psychosis. *Psychosis, 8*(3), 203-213. https://doi.org/10.1080/17522439.2015.1131323

Hamilton, A. B., & Finley, E. P. (2019, Oct). Qualitative methods in implementation research: An introduction. *Psychiatry Res, 280*, 112516. https://doi.org/10.1016/j.psychres.2019.112516

Hasler, B. S., Spanlang, B., & Slater, M. (2017). Virtual race transformation reverses racial in-group bias. *PloS one, 12*(4), e0174965. https://doi.org/10.1371/journal.pone.0174965

Hopkins, J. E., Loeb, S. J., & Fick, D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: a literature review. *Journal of Psychiatric and Mental Health Nursing, 16*(10), 927-937. https://doi.org/10.1111/j.1365-2850.2009.01501.x

Hughes, R., Hayward, M., & Finlay, W. M. L. (2009, 2009/01/01). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of mental Health, 18*(2), 152-160. https://doi.org/10.1080/09638230802053326

Katsakou, C., Rose, D., Amos, T., Bowers, L., McCabe, R., Oliver, D., Wykes, T., & Priebe, S. (2012). Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. *Social psychiatry and psychiatric epidemiology, 47*(7), 1169-1179.

Keown, P., Murphy, H., McKenna, D., & McKinnon, I. (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. *The British Journal of Psychiatry, 213*(4), 595-599.

Knight, M., Bunch, K., Tuffnell, D., Shakespeare, J., Kotnis, R., Kenyon, S., & Kurinczuk, J. J. (Eds.). (2019). *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17*. MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford.

Lawlor, C., Johnson, S., Cole, L., & Howard, L. M. (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.

Lloyd-Evans, B., Slade, M., Jagielska, D., & Johnson, S. (2009). Residential alternatives to acute psychiatric hospital admission: systematic review. *The British Journal of Psychiatry, 195*(2), 109-117.

Lloyd-Evans, B., & Johnson, S. (2019). Community alternatives to inpatient admissions in psychiatry. *World Psychiatry, 18*(1), 31.

Lu, W., Mueser, K. T., Rosenberg, S. D., Yanos, P. T., & Mahmoud, N. (2017). Posttraumatic reactions to psychosis: A qualitative analysis. *Frontiers in psychiatry, 8*, 129.

Mann, F., Fisher, H. L., Major, B., Lawrence, J., Tapfumaneyi, A., Joyce, J., Hinton, M. F., & Johnson, S. (2014). Ethnic variations in compulsory detention and hospital admission for psychosis across four UK Early Intervention Services. *BMC psychiatry, 14*(1), 256.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International journal of mental health nursing, 23*(3), 212-220.

McCabe, R., John, P., Dooley, J., Healey, P., Cushing, A., Kingdon, D., Bremner, S., & Priebe, S. (2016). Training to enhance psychiatrist communication with patients with psychosis (TEMPO): cluster randomised controlled trial. *The British Journal of Psychiatry, 209*(6), 517-524.

Mitchell, C. (2018, 14th January). Why the Mental Health Act needs to change. https://www.mind.org.uk/information-support/your-stories/why-the-mental-health-act-needs-to-change/#.Xh1l_y2cbOR

Moreno-Poyato, A. R., Montesó-Curto, P., Delgado-Hito, P., Suárez-Pérez, R., Aceña-Domínguez, R., Carreras-Salvador, R., Leyva-Moral, J. M., Lluch-Canut, T., & Roldán-Merino, J. F. (2016). The therapeutic relationship in inpatient psychiatric care: A narrative review of the perspective of nurses and patients. *Archives of Psychiatric Nursing, 30*(6), 782-787.

NHS Digital. (2019). *Mental Health Act Statistics. Annual Figures. England, 2018-19*. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures#summary

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). ‘It's unbelievably humiliating’—Patients' expressions of negative effects of coercion in mental health care. *International journal of law and psychiatry, 49*, 147-153.

Office for National Statistics. (2020). *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020*. Office for

National Statistics. Retrieved 13th July 2020 from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

Pistrang, N., & Barker, C. (2012). Varieties of qualitative research: A pragmatic approach to selecting methods.

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: a discussion and critique. *Nurse researcher, 18*(3).

Prins, H. A., Backer-Holst, T., Francis, E., & Keitch, I. (1993). *Report of the Committee of Inquiry Into the Death in Broadmoor Hospital of Orville Blackwood, and a Review of the Deaths of Two Other Afro-Caribbean Patients: "Big, Black and Dangerous?"*.

Rodrigues, R., & Anderson, K. K. (2017). The traumatic experience of first-episode psychosis: A systematic review and meta-analysis. *Schizophrenia research, 189*, 27-36.

Seed, T., Fox, J. R., & Berry, K. (2016, Sep). The experience of involuntary detention in acute psychiatric care. A review and synthesis of qualitative studies. *Int J Nurs Stud, 61*, 82-94. https://doi.org/10.1016/j.ijnurstu.2016.05.014

Shattell, M. M., Andes, M., & Thomas, S. P. (2008). How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry, 15*(3), 242-250.

Sheather, J. (2018). Reviewing the Mental Health Act—we need to talk about autonomy. *The BMJ Opinion*. https://blogs.bmj.com/bmj/2018/03/26/julian-sheather-reviewing-the-mental-health-act-we-need-to-talk-about-autonomy/

Shoreditch Ward. (2019). *Flip the Tringle - Award winning QI work*. Retrieved 12th July 2020 from https://qi.elft.nhs.uk/flip-the-triangle-award-winning-qi-work/

Singh, S. P., & Burns, T. (2006). Race and mental health: there is more to race than racism. *Bmj, 333*(7569), 648-651.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, J. A., & Osborn, M. (2015). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 25-52). SAGE Publications LTD.

Sofaer, S. (1999). Qualitative methods: what are they and why use them? *Health services research, 34*(5 Pt 2), 1101.

Starks, H., & Brown Trinidad, S. (2007, 2007/12/01). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, *17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Szmukler, G., & Holloway, F. (2000). Reform of the Mental Health Act: health or safety? *The British Journal of Psychiatry, 177*(3), 196-200.

Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., & Moore, E. (2013, 2013/04/01). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services? *The Journal of Forensic Psychiatry & Psychology*, *24*(2), 160-178. https://doi.org/10.1080/14789949.2012.760642

Theodoridou, A., Schlatter, F., Ajdacic, V., Rossler, W., & Jager, M. (2012, Dec 30). Therapeutic relationship in the context of perceived coercion in a psychiatric population. *Psychiatry Res*, *200*(2-3), 939-944. https://doi.org/10.1016/j.psychres.2012.04.012

van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., Griffin, J. M., Fu, S. S., & Perry, S. (2011, Apr 1). The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making. *Du Bois Rev*, *8*(1), 199-218. https://doi.org/10.1017/S1742058X11000191

Ward, L. (2013, Apr). Ready, aim fire! Mental health nurses under siege in acute inpatient facilities. *Issues Ment Health Nurs*, *34*(4), 281-287. https://doi.org/10.3109/01612840.2012.742603

Wyder, M., Bland, R., Blythe, A., Matarasso, B., & Crompton, D. (2015). Therapeutic relationships and involuntary treatment orders: Service users' interactions with health-care professionals on the ward. *International journal of mental health nursing, 24*(2), 181-189.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15*(2), 215-228.

Zavala, A. M., Day, G. E., Plummer, D., & Bamford-Wade, A. (2018). Decision-making under pressure: medical errors in uncertain and dynamic environments. *Australian Health Review, 42*(4), 395-402. https://doi.org/https://doi.org/10.1071/AH16088

Zestcott, C. A., Blair, I. V., & Stone, J. (2016). Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review. *Group processes & intergroup relations : GPIR, 19*(4), 528-542. https://doi.org/10.1177/1368430216642029

Part III: Critical Appraisal

Why I chose to study this topic

The topic of study, Black women's experiences of the decision to be sectioned, stood out to me as something that I want to pursue for two main reasons. Firstly, understanding the racial inequalities in sectioning and how stark these are for Black women in particular not only connected with my own identity as a Black woman but also my personal values of justice, freedom, independence and compassion. It felt important that I use my training and position as an opportunity to give Black women a chance to be heard in a space where they are often excluded.

Secondly, being one of only two Black trainees in my training cohort, when this project was proposed for someone to take up, I somewhat felt a sense of responsibility to ensure that the project happened. Outside of clinical training I do a lot of work in improving racial diversity in clinical psychology and improving the training experience for people from minoritised ethnic groups. It is really interesting to notice how motivation the do certain research projects may differ amongst a cohort. I recall being mindful that if I did not take this project, it was possible that others would not feel able to, perhaps because of discomforts with talking about race, or that it might not stand out as relevant in the same way for them. It was the pull to my culture and community that kept me connected with this study throughout my clinical training.

How did my personal characteristics link in with and shape the research?

As a Black woman, I am exposed to the racial inequalities associated with living in the UK. This meant that I could connect with conversations about living at the intersect of being Black and being a woman, and the experience of naming the challenges associate with this. Furthermore, working in mental health services, and at the time of the interviews, in a context where people were admitted under the mental health act gave me some sense of the position in which the women interviewed were placed.

I had hoped that my being a Black woman would be an asset to this research project by having our shared identity be helpful for building rapport quickly during the interview. I think that happened, and I felt as though there was a shared experience between the women and I, however I also acknowledged differences too. Noticing these was important for ensuring that I did not over-identify and make assumptions about the women’s experiences based on my own.

For example, one of the main things that I noticed was our difference in social class. Although my parents would identify as working-class, I would find it unfair to identify myself as working class with the lifestyle and privileges that I have now. I was conscious of how this may have been perceived by the women I met and whether this would influence our conversation; the fact that we shared race but had clearly had very different life experiences is terms of housing, education, and employment circumstances.

I also noticed that while the women and I shared a race, we had very different cultures. Two of the women I spoke with were of African heritage, while my family are Caribbean, and three of them were a generation above me. There is so much nuance in what it means to be a ‘Black’ person, with life stories and experiences being shaped by the country you and your family are from, and the cultural identity you have. I was keen to try to understand and respect this as much as possible. Being around older Black women activated cultural ideas of respecting older people and being more reticent and passive in their presence, however this was at odds with my position as the researcher. I noticed that my tone with the participant who was younger than me and British born was respectful but in a different way to my tone when talking with women older than me and born outside of the UK. I also wondered what it might be like for them to be talking to me about their experiences; upon leaving and interview one woman likened me to her daughter, which led me to wonder whether how she felt to have shared her experiences in such detail with me.

I understand my change in tone as being part of a resolution for the conflict that arose between wanting to respect my elders in the traditional sense, where the power dynamic is dominated by them, and my speaking with them as a doctorate student and NHS clinician asking questions about a challenging and personal experience, where the power dynamic is somewhat more dominated by me. This was anticipated prior to beginning data collection and was something that PPI helped to tackle. The PPI involvement in the study design process helped to ensure that the phrasing of questions remained respectful and honoured the position of the people that I would be speaking to. It also helped me to notice any assumptions that had been made in the initial question development, with an aim of achieving a more neutral and balanced stance that would privilege the expression and sense-making of the women that I interviewed. This was a humbling and valuable experience, and I hope to develop the way in which I engage with experts-by-experience in future research by using co-production.

Engaging with the research topic in the context of coronavirus and Black Lives Matter movement

Coronavirus has been a game changer for the study and for my experience of this research topic. In practical terms, coronavirus significantly affected my recruitment as it had to be stopped immediately. This was a shame because it had been slow off the ground to begin with. Given my personal investment in the topic, this was frustrating for me as I wanted to ensure that the data captured the women's experiences in the most meaningful way, however I also valued the opportunity to spend more time on the analysis of the conversations with the four women I did get to see. I was able to focus on honouring their experiences and really pay attention to exactly what they said in detail.

The coronavirus pandemic and the increased public attention on the Black Lives Matter movement also affected the way in which I could engage in this research. Coronavirus shed a brighter light on the existing health inequalities in the UK and the increased awareness of the Black Lives Matter movement ignited much needed conversations about racism, and that fact that it is a problem in the UK too. While I was grateful that these issues were being more carefully considered, it was incredibly tiring, draining and upsetting to be witnessing so many Black lives being taken by police brutality or by the virus. In addition, conducting this research about other healthcare inequalities where Black people are most affected became very raw and painful at times, making it much more challenging to 1) engage with and 2) engage with in an impartial manner.

These incidents affected the whole nation, but in particular the Black community, so I was mindful of the experiences that the women that I interviewed might be having during that time too. Our intention had been for the women to review the highest level of themes extracted from their interviews to ensure that the analysis remained close to their experience of our conversation, however it felt important to delay contacting them for this until the coronavirus and Black Lives Matters issues were not so prominent. When I did contact them as late as possible, the women that I managed to get through to informed me that they were feeling exhausted and drained at the time and did not feel as though they wanted to revisit the discussions. This highlighted to me the importance of considering participants' wider contexts when conducting research remembering the experience of participating cannot be divorced from a person's experience of the rest of the world. I am curious as to whether the women might have felt hesitant about revisiting the key themes regardless of the pandemic and Black Lives Matters movement, as the conversation felt very raw and their experience of being detained was negative for most of the women.

My personal perspective on the underlying causes of the ethnic disparities in compulsory detention also changed as a result of the coronavirus pandemic and Black Lives Matters movements and the conversations that I had with the women interviewed. Prior to completing the study, I strongly believed that racism had an important role to play in the disparities, and that racism largely lay at the level of the healthcare professionals making the decision for the person to be detained. I worked hard to keep my perspective on the topic distinct from the interviews, although I recognise that in some ways it will have informed the questions that I thought of and chose to (or not to) ask. Through reflecting on this and being aware that this was a more dominant narrative that I held about this issue problem, I held in mind how important it was consciously put my beliefs about the role of racism to one side. I made all efforts to privilege the participant's story and their understanding during the interviews and analysis rather than impose my own. I believe I was successful in achieving this as most women did not name racism nor reported that their ethnicity influenced the decision for them to be detained.

Looking back on my perspective prior to the study, I understand why I held that belief about the role on racism at the individual level, however I now view that as rather naïve and simplistic, driven by the sense that someone is to blame for the inequalities. I began to question my beliefs following the interviews where women mostly stated that their ethnicity did not play a role.

When the disparities in coronavirus deaths began to be reported and the Black Lives Matter movement highlighted systemic racism, my belief that racism has a large role to play in the disparities was strengthened however my understanding of how racism might be involved changed. As reported in the discussion section of the empirical paper and conceptualised in the contextual model proposed in Part I, I now understand systemic racism to be playing an important but subtle role in the ethnic disparities in compulsory detention. I understand this form of racism to function in a way that sets up people up to be more likely to be detained not necessarily just because of the implicitly or explicitly racist attitudes of healthcare professionals, but rather as result of a series on cumulative effects of racism across social and institutional structures that is pervasive throughout our government policy and throughout society.

So then in terms of beginning to form a solution to the problem, from my perspective, the pandemic and recent protesting against systemic racism has shown that ethnic disparities in compulsory detention requires all parties in the entire system in which a Black person may be embedded to ensure that Black people are not being more negatively affected by the way in which it functions. I have thought more recently about what the role of a clinical psychologist might be in actioning this. My current clinical placement in the public health team of a third sector charity has demonstrated to me that a psychologists role could be to facilitate thought-provoking conversations that encourage people to reflect on what is informing their policies and their decisions, and to hold the perspective of Black people, and especially Black women in mind. I believe psychologists can also be excellent advocates for people who experiencing oppression, by noticing when their voices are and are not being heard, and how they are being listened to. Using research skills, clinical psychologists can continue to empower Black people to share their experiences and be involved in shaping to production of knowledge that could inform future policies. This perspective may be deemed controversial, as there are debates around whether psychologists should ‘be political’; I would argue that a psychologist’s skillset has a lot to offer in times of oppression and is an excellent use of the listening and learning that psychologists do.

Other challenges faced when conducting this research

There are two specific areas that come to mind when thinking about other challenges faced in this research project, including recruitment challenges and the transition from quantitative to qualitative research.

Recruitment was slow to begin with and I found the main barrier to be that I was not clinically embedded in the team that I was working with, so I was required to be more proactive about informing and reminding each clinical team in the trust about the research project. Initially, I did not realise how much this would be needed and turning up to team meetings was something that I found personally quite daunting and challenging. Over time this got easier and building a rapport with the team helped to solidify the project’s presence. Furthermore having a person in each team helping to advocate for recruitment when I could not be present really helped. This has taught me about the challenges of recruiting for a research project in a clinical team separate to where I am working and the importance of building relationships. It also helped me to feel more confident in approaching other teams to conduct meaningful research.

The majority of my research training in previous and current academic programmes has been in quantitative approaches, however it felt important to honour the fullness of the women's experiences by using a qualitative approach in this study. Throughout clinical psychology training, where I have had the opportunity to hear others share such a variety of life stories, and through fostering genuine curiosity in understanding how society has come to function the way in which it does, I believe that my worldview is much more aligned with social constructionist principles than ever before. This is somewhat at odds with my academic training to date, so combining a social constructionist perspective with the in-depth analysis of a complex social issue and the production of a doctoral thesis has required consistent reflection, intentional action, and checking-in with others. I did notice that when exploring I would at times slip into intellectualising, wanting to know numbers and trends, or looking for finite and measurable solutions. It took a while for me to stop thinking comparatively, and to hold in mind that having a control group or second experimental group was not appropriate or fitting for the approach that I was using and the research questions that I was asking. Noticing this has helped me to pay attention and notice what has guided important decisions throughout the research process.

The Mental Health Act (1983): The rationale behind its use and the potential for alternatives

The Mental Health Act (1983) describes the rights of people experiencing mental health distress, outlining the guidelines for compulsory assessment and treatment in hospitals and in the community. It is comprised of various sections under which people may be involuntarily detained in hospital against their will for specified periods of time (see Table 1 for more details on each section). Compulsory detention may happen if it is deemed that a person meets the criteria for a diagnosis of a mental disorder and that detention is necessary for the health or safety of themselves or other people. The aims of the Mental Health Act remains to be a contentious issue; it is unclear whether the Mental Health Act is needed to protect those who lack capacity, to protect the public from risk of harm by people experiencing mental health crises, or to reduce the anxieties of risk-averse mental health professionals (Szmukler & Holloway, 2000).

The Mental Health Act presents society and state with a socio-political paradox. It serves to help those who would benefit from treatment for their mental health illness, with an intention to also protect the patient and the public from risk of harm, however it is a monumental imposition on freedom and liberty, which can be a distressing and traumatic experience for those of on who it is used and for their friends and family members.

The Mental Health Act 1959 shifted compulsory care of people with mental health problems from being a solely legal issue focused on containment to being a paternalistic issue that focused more on treatment, where patients' best interests were intended to be central to decisions made (Keown et al., 2018; Szmukler & Holloway, 2000). However, there has since been a steady rise in formal admissions using the rights outlined in the Mental Health Act. Despite the reformed Mental Health Act 1983 somewhat restricting mental health professionals' powers while bolstering patients' rights, the increase in compulsory detention rates has persisted (Szmukler & Holloway, 2000).

In the 1990's, ideas of 'public safety' and 'community care' became dominant in the narrative around mental health, which was powerfully contributed to and maintained by various forms of popular media. Films such as The Shining (1980), A Nightmare on Elm Street (1984), Psycho (1960) and the increase in newspaper articles referring to mental illness as being dangerous to others (Goulden et al., 2011) reinforced the idea that to be attributed a diagnosis of a mental health problem is to be dangerous. With this came the implication that the state is responsible for ensuring that members of the public are safe from the harm that could be caused by these 'dangerous people', by increasing the levels of control given to mental health professionals, particularly in regard to ensuring compliance with community treatment.

This risk-focused narrative led to a perceived need for the further reforms of the Mental Health Act. The 1995 amendment of the 1983 Mental Health Act introduced supervised discharge orders (SDOs), which stipulated supervised treatment in the community following involuntary hospital detention. In the 2007 Mental Health Act reform, SDOs were replaced with community treatment orders (CTOs) which extended the powers to include the possibility to recall to hospital for detention under the original section. Despite the 2007 expert committee endorsing key principles of non-discrimination for those with mental health problems and respect for patients' autonomy, the conclusions outlined in the Government's subsequent Green paper were largely motivated by issues of risk and risk aversion.

In recognition of concerns that, following the 2007 reform, the Mental Health Act did not consider the needs of the individual enough and was unable to adequately meet the needs of a more culturally diverse Britain (Department of Health and Social Care, 2017; Mitchell, 2018; Sheather, 2018) a further Independent Review of the Mental Health Act was commissioned and a final report produced in 2019 (Department of Health and Social Care, 2019a, 2019b). This review focused on ‘restoring dignity to people and to the system’, recognising that increased choice and more meaningful decision-making processes are essential to achieve this aim while acknowledging that applications of the Mental Health Act will.

Although the dominate approach in the UK is still involuntary admission, there are potential alternative approaches to managing acutely ‘high-risk’ mental health problems. Acute day care, crisis teams, and residential crisis houses have all been shown to have similar outcomes to involuntary admission (Lloyd-Evans et al., 2009). However, there are potential barriers to implementing these more community-based approaches, for example the need to be prepared and able to respond to high levels of risk in an outpatient setting – this would require staff to be well-supported in their roles – and the need to respond to the high levels of risk very quickly – this will require adequate resourcing and efficient processes to be in place (Lloyd-Evans & Johnson, 2019).

Appendices

Appendix 1: Interview schedule

REC Reference: 19/LO/1584

Interview schedule

Study title: Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services

Information sheet reviewed and consent forms completed. Interview session begins.

Introduction

Thank you for meeting with me today and agreeing to take part in the study.

I have here that your name is …. What name do you prefer to be called by?

Ok, thank you [preferred name].

Explain information about the study, as provided on the study information sheet, giving opportunities for the participant to ask questions

I will begin by summarising the study.

We are conducting this research projects to find out more about Black women's experiences of being taken to hospital under section. During this session, we will be having a conversation about what happened when the decision was made that you were going to be sectioned and I will be asking questions to try to get a better understanding of what that was like for you. I have some prepared questions but you are also welcome to let me know if you have any additional comments or questions *throughout the session. While we're talking, I encourage you to be as honest and open as you feel you can be as I really want to hear about your own experiences and views. There are no right or wrong answers to any of the questions that I ask. I expect that this conversation will last between 30 mins and 1 hour. If you would like a break at any point, that is fine, just let me know. Please remember that if the conversation becomes too difficult, you can stop talking at any time.*

How does that sounds to you? Do you have any questions at the moment?

As you might remember, session will be recorded so that I can revisit the conversation later. I would like to take this opportunity to remind you that everything you say will remain completely anonymous.

If you happy to continue with the session today, please can you carefully read through and sign this consent form. You are welcome to ask any questions that might come to mind when reading this.

Engaging participant

Throughout this interview, I'm going to be asking you questions about being admitted to hospital involuntarily, also known as 'being sectioned'. I'm very keen to hear and understand your experiences and thoughts, so I encourage you to be as honest as possible. If there is anything that we don't cover throughout the interview that you feel is important to include, please feel free to share this with me. We will have time after the questions to talk about this.

Firstly, I will begin by asking a few questions about your personal characteristics.

Demographic characteristics

1. **What is your age?**
2. **What ethnicity do you identify as?**

   - *For example, Black African woman, Black Caribbean woman, Black British woman, Black other*

3. Although the term ‘Black’ is frequently used to describe people of African and Caribbean heritage, we know there is a lot of variation within being ‘Black’. To make sure we consider this, we would also like to find out what people’s heritage and/or journey to the UK has been. **What country were you born in?**
   - *If born in the U.K.:* And which generation of your family came to the UK? Whereabouts were your family from before moving to the UK?
   - *If not born in the U.K.:* What brought you to the U.K.?
4. **Do you do you follow a faith or belief system?**
   - If yes, what faith/belief system do you identify with?
   - How important is your faith/belief system to you?
5. **What is your gender identity?**
6. **How many times have you been sectioned under the Mental Health Act? When did that happen?**
7. **In your own words, how do you define the ‘symptoms’ that you have been experiencing e.g. as mental health difficulties, stress, or anything else?**

Thank you for explaining that for me. Now let’s move on to the next section of the interview. I’m now going to ask about your experience(s) being sectioned under the Mental Health Act.

Experience of compulsory detention

Interviewer to facilitate story-telling.

8. **Can you tell me what happened when you were sectioned?**

- What led up to the section happening (i.e. what was happening on the day that led to the section taking place?)
- Did you know that you were being taken to hospital?
- Who made the decision for you to be taken to hospital under a section?
- How many people were in the room when the section took place?
- Who were they?
- How many people were involved in the decision?
- What did they tell you?/What reasons did people give about why you were being taken to hospital?
    - (if some) what did you think about that/what did you make of their reasons? How did you feel?
    - (if none) what was it like for you to not know why they wanted you to go to hospital? How did you feel? Why did you think you were being taken to hospital?

9. **On reflection, do you think that being sectioned was helpful decision at the time?**

<u>Making sense of the experience</u>

10. **How did other people interpret/make sense of *insert behaviour here* at the time?**
    - How much is that similar or different to how you saw it?
    - (If different) How much was this difference of opinion discussed at the time?
    - Is there anything that you were doing that was misunderstood?
    - On reflection, how do you see your behaviour now?
11. **How much did people listen to your understanding of the experience?**
    - How much did people listen to your perspective of the situation at the time?

    - How seriously was your view taken?

12. **How much did other people's opinions impact the decision? (e.g. your family)**
    - How do you feel about that?

Learning from the experience

13. **On reflection, do you think that being sectioned was helpful decision at the time?**
14. **Was there anything that other people did that you think was particularly helpful at the time?**
15. **Looking back, was there anything that other people (professionals, family members or yourself) could have been done differently? Was there anything that could have been understood differently?**
    - What would have made a difference to your experience of the decision being made to detain you?
    - What aspects of your life and your experiences then or now were not taken into consideration?

For the final part of the interview, I would like to ask some questions about the impact you think yours or others personal characteristics could have had on the decision made for you to be taken to hospital under section. When talking about personal characteristics, I mean factors such as gender, ethnicity, skin colour, nationality, religion, social class, education level, employment status, relationship status, family support, housing situation etc.

Impact of personal characteristics on involuntary hospitalisation

16. **Do you think any of your personal characteristics influenced the decision to section you?**

    If yes: Please can you tell me more about this?

If no: What leads you to think this?

17. **From what you can remember, what were the personal characteristics of the people involved in the decision to section? Do you think their personal characteristics influenced the decision to section you?**

If yes: Please can you tell me more about this?

If no: What leads you to think this?

What do you think of the last two questions?

Do you have any ideas about why you think I asked you this?

Offer a break here.

I’m now going to ask you to mark on a line how much a range of personal characteristics and clinical factors you think influenced the decision to admit you to hospital. Please mark the line with a cross.

18. **How much do you think the following factors influenced the decision to take you to hospital under section:**

Being at risk of harm to yourself

Being at risk of harm to others

Not at all Completely

Needing a mental health assessment

Not at all Completely

Needing more support/treatment than what could be provided in the community

Not at all Completely

Your behaviour

Not at all Completely

Education level (my education level is: ___)

Not at all Completely

Social class (my social class is: ____)

Not at all Completely

Religion

Not at all Completely

Ethnicity/Race/Skin colour (please select)

Not at all Completely

Gender

Not at all Completely

My ethnicity and gender combined (i.e. being a Black woman)

Not at all Completely

Other: ______________________________________

Not at all Completely

Other: ________________________________

Not at all ├────────────┼────────────┤ Completely

Other: ________________________________

Not at all ├────────────┼────────────┤ Completely

We have come to the end of the interview questions. Thank you for taking the time to explain your views and experiences to me. Is there anything else that you would like to add about we've discussed so far?

For the final part of the session today, it would be helpful to discuss with you the impact of possible traumatic or stressful life events that you may have experienced. To do this, we will go through two short questionnaires together before finishing. Do you have any questions about this?

COMPLETE TALE CHECKLIST AND, IF TRAUMATIC EVENT IDENTIFIED, THE INTERNATIONAL TRAUMA QUESTIONNAIRE.

Close

We are now at the end of the questionnaires. Thank you for your time and for sharing your thoughts with me today.

How was the experience of doing this interview for you?

Remind participants that after leaving the interview, if at any point they feel upset, worried or distressed they can contact their care coordinator or call the Samaritans 24/7. Give participants contact details for the Samaritans.

Appendix 2: Interview schedule consultation process

Step 1: Interview schedule development

The research team derived questions based on recommendations for further research from previous studies of ethnic disparities in compulsory detention and from considering how to generate information relevant to the aims of the study. Items include questions exploring demographic characteristics, experiences of compulsory detention, and perspectives on the impact of race and gender on experiences of detention.

Step 2: Expert opinion with qualitative researcher

Professor Nancy Pistrang, an expert in qualitative research, was consulted to provide feedback and guidance on the styles of questions used to meet the aims of the study and address the research questions. On the basis of her comments on wording, question order, and interview style, changes were made to the interview schedule.

Step 3: Further refining the interview schedule with Experts

Consultations with Dr Taiwo Afuape, and expert in race-relations research and trauma, and Claire Williams, a social worker with experience detaining under the Mental Health Act, generated feedback on the focus of each of the questions. Specifically, the feedback helped to ensure that the topics discussed in the interview were relevant and fully addressed the aims of the study. This feedback was incorporated to generate the next version of the interview schedule.

Step 4: Consultation with Experts-by-Experience

Five Experts-by-Experience were consulted for the final stages of interview schedule development. Two of the experts-by-experience were Black women with experience of being sectioned who met eligibility criteria for the study. Experts by experience provided feedback on the recruitment poster, information sheet, consent form and interview schedule. Their feedback helped shape the final wordings of questions, to ensure that they were clear, felt relevant, and addressed difficult topics in a sensitive manner.

Step 5 Final version incorporates amendments:

Version 2.5 of the interview schedule incorporated the suggestions made by all experts to form the final version of the interview schedule.

Appendix 3: Demographics questionnaire

REC Reference: 19/LO/1584

Study title: Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services

Demographic characteristics

Participant ID :___________________

1. **What is your age?**
2. **What ethnicity do you identify as?**
   - *For example, Black African, Black Caribbean, Black British, Black other*
3. Although the term 'Black' is frequently used to describe people of African and Caribbean heritage, we know there is a lot of variation within being 'Black'. To make sure we consider this, we would also like to find out what people's heritage and/or journey to the UK has been. **What country were you born in?**
   - *If born in the U.K.:* And which generation of your family came to the UK? Whereabouts were your family from before moving to the UK?
   - *If not born in the U.K.:* What brought you to the U.K.?
4. **Do you follow a faith or belief system?**
   - If yes, what faith/belief system do you identify with?
   - How important is your faith/belief system to you?
5. **What is your gender identity?**
6. **What is your marital status?**
7. **What is you highest level of education?**
8. **What is your employment status?**
9. **What are you current living arrangements (i.e. alone, with others, roofless, other)?**

Appendix 4: Trauma and Life Events (TALE) checklist

Trauma And Life Events (TALE) Checklist

This checklist includes a list of common traumatic or stressful life events. We would like to know whether or not you have ever experienced these events and, if so, which has the most impact on you now. If you choose to answer, please just indicate which events you experienced, if they happened more than once, and how old you were when they happened. Thank you.

Participant ID: _______________

Have you ever experienced…? (Please see brackets for some examples)	**Yes (✓) or No (✗)**	**More than once? Yes (✓)/No (✗)**	**Age(s)** – range if repeated
1. Exposure to war, either in the military or as a civilian? (e.g. combat, ongoing civil unrest, torture, becoming a refugee or political prisoner)			
2. Loss of, or permanent separation from someone close to you such as a parents or caregiver (e.g. due to death, being placed in care, conflict, divorce)			
3. A period of separation from someone close to you such a parent or caregiver (e.g. due to being placed in care, illness, conflict, divorce)			
4. Sudden or unexpected move of change in circumstances (e.g. changing school, loss of home)			
5. Bullying or harassment at school, work or on the street (e.g. people saying hurtful things, hitting or shoving)			
6. Discrimination at school, work or on the street? (e.g. being ignored or treated differently)			
7. Someone close to you insulting you, putting you down or humiliating you?			

(e.g. someone you live with /partner/family member/caregiver)			
8. Someone close to you being physically violent or aggressive towards you? (e.g. partner/parent, hitting/kicking/throwing things)			
9. Witnessing physical violence or verbal aggression in your home? (e.g. parents fighting, seeing siblings being beaten or hurt)			
10. Someone you did not known being physically violent or aggressive towards you? (e.g. mugging, assault, fight)			
Have you ever experienced…? (Please see brackets for some examples)	**Yes (✓) or No (✗)**	**More than once? Yes (✓)/No (✗)**	**Age(s)** – range if repeated
11. Feeling unsafe, unloved or unimportant during childhood? (e.g. no one to look out for you)			
12. Going hungry or thirsty, not having clean clothes or a safe place to stay during childhood?			
13. Someone having sexual contact with you, before your 16th birthday, that either at the time or looking back on it now was unwanted? (e.g. talking, looking, touching, penetration)			
14. Someone having any sexual contact with you, since your 16th birthday, that either at the time or looking back on it now was unwanted? (e.g. talking, looking, touching, penetration)			
15. Unusual experiences, such as hearing voices, seeing visions or having worries about other people causing you harm, that made you feel in danger or distress?			
16. Acting in ways that put you or someone else in danger or were strange or embarrassing? (e.g. wandering the streets at night, violence, risky sexual behaviour)			

17. Contact with mental health services (e.g. being admitted to hospital) that involved threatening or upsetting events? (e/g/ being restrained, coerced, secluded, assaulted, forced to take medicine, or witnessing such events)			
18. Any other contact with health or criminal justice services which was upsetting or frightening?			
19. Any other events that were accidental or did not involve people intending to cause you harm? (e.g. serious illness, accidents, fire, natural disaster)			
20. Apart from the above, has anything else happened in your life that you found distressing? Please specify:			
21a. Do any of the events you have mentioned, that ended at least 1 months ago, still affect you now?	**Yes / No**		
21b. Which event or events currently affect you most? Event number(s):			
21c. Overall, how much are you affected now by the event or events select in 21b (from 0 = not at all to 10 = extremely)			

Appendix 5: International Trauma Questionnaire

Interviewer: Only complete if traumatic/stressful life events are stated as having an impact in TALE Q21A

International Trauma Questionnaire

Participant ID: ________________

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience

____

When did the experience occur? (circle one)

a. less than 6 months ago

b. 6 to 12 months ago

c. 1 to 5 years ago

d. 5 to 10 years ago

e. 10 to 20 years ago

f. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
P5. Being “super-alert”, watchful, or on guard?	0	1	2	3	4
P6. Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:

	Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
P7. Affected your relationships or social life?	0	1	2	3	4
P8. Affected your work or ability to work?	0	1	2	3	4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
C1. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2. I feel numb or emotionally shut down.					

	0	1	2	3	4
C3. I feel like a failure.	0	1	2	3	4
C4. I feel worthless.	0	1	2	3	4
C5. I feel distant or cut off from people.	0	1	2	3	4
C6. I find it hard to stay emotionally close to people.	0	1	2	3	4

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

C7. Created concern or distress about your relationships or social life?	0	1	2	3	4
C8. Affected your work or ability to work?	0	1	2	3	4
C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Cloitre et al. (2018) Acta Psychiatrica Scandinavica. DOI: 10.1111/acps.12956

Appendix 6: Recruitment flyer

HAVE YOU BEEN SECTIONED UNDER THE MENTAL HEALTH ACT?

ARE YOU UNDER THE CARE OF EARLY INTERVENTION SERVICES?

DO YOU IDENTIFY AS A BLACK WOMAN?

If you answered ‘yes’ to all the questions above and would like to share your experiences, we would like to hear from you.

What is this research about?

We want to hear Black women’s views about when it was decided that they would be sectioned (involuntarily admitted to hospital).

What is involved?

- An interview about your experiences of the time(s) it was decided that you would be sectioned.
- Complete 1-2 short questionnaires asking whether you have experienced a list of potentially adverse experiences

How many times will we meet?

- One meeting for approximately 1 hour and 30 minutes at a convenient location.

You will not have to answer any questions that you do not want to.

All your answers will be anonymised and kept confidential.

Who can take part?

We invite English-speaking **Black women over 18 years old** under the care of **Early Intervention Services (EIS)** who have **been sectioned within the last 11 months**.

All participants will receive £15 for taking part in the research.

If you are interested in participating or would like to find out more, please contact the researcher, Samantha Rennalls, at BlackWomenEIS@gmail.com (07394 473 474)

Appendix 7: Participant information sheet

REC Reference: 19/LO/1584

Study title: Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services

We would like to invite you to take part in this postgraduate research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, please read this information sheet carefully and discuss it with others if you wish, so you understand why the research is being done and what your participation would involve. Part 1 tells you the purpose of this study and what will happen if you choose to take part. Part 2 gives you more detailed information about how the study is managed. Please ask us if there is anything that is not clear or if you would like more information.

Part 1

What is the purpose of the study?

Understanding people's experiences of mental health services is important for improving services. There are gender and ethnic variations in rates of involuntary admission to hospital (this is referred to as 'being sectioned under the Mental Health Act'). This study aims to gain insight into people's experiences of the times when it was decided that they would be admitted to hospital against their will.

We hope that this will help us identify important factors that might influence disparities in rates of sectioning and produce meaningful recommendations for professionals involved in the sectioning process.

Who can take part:

We have invited people to take part in this research who are:

(1) Of female identity
(2) Of Black ethnicity
(3) Aged over 18 years
(4) Able to understand and communicate in spoken English
(5) Under the care of an Early Intervention for psychosis Service (EIS)
(6) Have been sectioned under the Mental Health Act at least 1 month, but no longer than 12 months ago

Who must we exclude?

Unfortunately, we must ask you to *not* participate if you:

(1) Are currently being assessed, or receiving treatment under a section of the Mental Health Act
(2) You were sectioned under the Mental Health Act less than 1 month ago or longer than 12 months ago

Do I have to participate?

You do not have to take part in this study. It is up to you to decide whether you wish to participate or not. If you decide to take part, we will ask your permission to use your anonymised responses in my doctoral thesis. We also plan to share our findings in research publications and/or presentations. You are free to withdraw at any time, without having to give a reason. This would not affect your current or future care.

What will happen if I decide to take part in the study?
If after reading this information sheet you are interested in taking part in the study, you will speak with the researcher to arrange a date and time for the session. The session will take place at a convenient site in the North East London NHS Foundation Trust. You will also be able to ask any questions about the study before deciding whether you would like to take part.

With your permission, the researcher will get confirmation of your diagnosis, and details about your section (e.g. date, type, length of section) from your clinical notes on the NELFT electronic system. You will meet with the researcher for one session lasting approximately 1 – 1½ hours. You will then complete an audio-recorded interview lasting about 1 hour where the researcher will ask about your experiences of the time that it was decided that you would be sectioned. After this conversation, you will be asked to complete up to two short questionnaires about whether you have experienced a list of potentially adverse experiences. There are no right or wrong answers to these questions, so we ask that you respond as honestly and openly as possible.

The interview session is audio recorded so that the researcher can transcribe the conversation after you have finished talking. The audio recording will be stored on an encrypted device and will be deleted as soon as the interview is transcribed. Transcriptions will be written by the researcher that conducted your interview and the researcher will remove any personal identifiable information so that the conversation will be completely anonymised. The researcher will identify key themes that arise during the interview and will choose some direct quotations to show examples of these themes in the final report.

Additional opportunity to offer consultation to the research team:
We will also invite participants to meet with the researcher in early 2020 to comment on their interpretation of the main themes emerging from your interview, including any anonymised quotations used. If you are interested in being involved in this additional part of the project, you will be invited to attend a second meeting when the researcher will show you the summary of themes identified and you will be asked about your feedback to ensure you feel they accurately represent your view.

Will I be compensated?
Yes. You will receive £15 in compensation for your time in taking part of the main study and expenses. Additionally, if you wish to attend a second meeting to contribute to ensuring the analysis is a fair reflection of your views, you will receive an additional £10.

What will happen to the results of the research study?
You will be offered the opportunity to receive a summary of the findings of the study. The results of the study will contribute to part of a dissertation thesis and be sent to an academic journal for publication, but you will not be identifiable. Your participation in the study will, of course, not be disclosed.

What are the possible disadvantages and risks of participating in this study?

You will be asked questions about your experiences of being sectioned and, for some people, this may be upsetting. Please be assured that any information you provide will be handled in the strictest confidence, and that you will be able to answer questions at your own pace.

The researcher is training to be a clinical psychologist so has experience in managing distress. If any time you feel upset, you can let the interviewer know so she can help you feel calm and re-orient you to the present. You can ask the interviewer to move on to another subject or terminate the interview altogether. You do not need to discuss anything that you do not want to and you should discuss only the things which you feel comfortable sharing.

In the event that you experience distress is experienced at the end of the interview, the researcher will remain with you until you feel better or ensure that you are not left alone and will ask whether they can highlight this to your allocated case worker. The researcher will call to check you are safe and well one week later.

What are the possible benefits of taking part?
Many people experience the opportunity to share their story to be positive. We hope that the findings of this study will give professionals important insight into what it is like for Black women when the decision is made to section them. We aim to share important and relevant factors with key stakeholders, including medical professionals and government departments.

What if there is a problem?
If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask the researcher if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor’s (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with your research doctor, please make the claim in writing to the Dr Miriam Fornells-Ambrojo who is the Chief Investigator for the research and is based at University College London. The Chief Investigator will then pass the claim to the Sponsor’s Insurers, via the Sponsor’s office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are at the end of the document. If you remain unhappy and wish to complain formally, you can do this via the hospital’s Patient Advisory Liaison Service (PALS). Information about how to contact your nearest PALS office are available here: https://www.bhrhospitals.nhs.uk/patient-advice-and-liaison-services.

This is the end of Part 1 of the information sheet.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making a decision.

Part 2

What will happen if I don't want to carry on with the study?

If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Will my participation be kept confidential?

We follow ethical and legal practice and all information about you will be handled in confidence. If you are under the care of a team in North East London Foundation Trust, we will inform them that you are taking part in the study. Otherwise, all the information about your participation in this study will usually be kept confidential. The only exception is if you tell us something that leads us to believe that you may be at risk of harming yourself or somebody else, or that you are at risk of harm from somebody. In this case we will need to inform the clinical team at the Early Intervention Service to make them aware of any risk. We will keep you informed about this.

All of your data will be stored and analysed in anonymised form. Only the lead researchers on the project will have access to your personal information and this will be kept separate from the data collected. Only researchers involved in this study and regulatory authorities will have access to the data. Data will be stored in locked offices and on password-protected databases at University College London. All information that is collected during the course of the research will be kept strictly confidential according to the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

We will only use your personal information to contact you if you have agreed to be contacted for participation in analysis or this study or in follow-up and future studies.

UCL is the sponsor for this study based in the United Kingdom. We will be using information from you and your medical records in order 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. UCL will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting the UCL Data Controller at data-protection@ucl.ac.uk.

North East London Foundation Trust will keep your name, NHS number and contact details confidential and will not pass this information to UCL. North East London Foundation Trust will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from UCL and regulatory organisations may look at your medical and research records to check the accuracy of the research study. UCL 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.

North East London Foundation Trust will keep identifiable information about you from this study for Less than 3 months after the study has finished.

UCL will collect information about you for this research study from NELFT. NELFT will not provide any identifying information about you to UCL. We will use this information to find out and confirm details of your clinical diagnosis.

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

Who has reviewed this study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by the London – Dulwich Research Ethics Committee (*REC Reference: 19/LO/1584)*

Who is organising and funding this study?
This study has been organised by UCL and funded by UCL DClinPsy

How have patients and the public been involved in this study?
Service user involvement was an important part of the study preparation, particularly in developing the interview schedule. Five Experts-by-Experience were consulted for the interview schedule development. Two of the experts-by-experience were Black women with experience of being sectioned who met eligibility criteria for the study. They provided feedback on the recruitment poster, information sheet, consent form and interview schedule. Their feedback helped shape the final wordings of questions, to ensure that they were clear, felt relevant, and addressed difficult topics in a sensitive manner.

Contact details:
General information about this research project can be obtained from Samantha Rennalls (Email: s.rennalls.17@ucl.ac.uk, Tel: 07394 473 474) and
Dr Miriam Fornells-Ambrojo (Email: miriam.fornells-ambrojo@ucl.ac.uk, Tel: 020 7679 1897)

Thank you for your interest in this study and for taking the time to read this information.
If you agree to part in the study, you will be given a copy of this information sheet and a copy of the signed consent form to keep.

Appendix 8: Written consent form

NELFT NHS
NHS Foundation Trust

UCL

REC Reference: 19/LO/1584

Study title: Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services

Consent form

*Researcher name:*_________________________ *Participant Identification Number:*________

Thank you for considering taking part in this research. The researcher must explain the project to you before you agree to take part. If you have any questions arising from the information sheet or explanation given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this consent form to keep and refer to at any time.

	Please initial
• I have read and understood the information sheet dated 01/11/19 (version 4.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
• I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected.	☐
• I understand that relevant sections of my clinical notes and data collected during the study, may be looked at by individuals from University College London, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
• I give consent for the research interview to be audio recorded for the purpose of later analysis of the discussion to achieve the aims of the study.	☐
• I give consent for anonymous quotations to be extracted from the audio recordings for use in future publications. I understand that these quotations will be anonymous. Declining to do so at any time will not affect my participation in the research in any way.	☐
• I understand that my Health Care professional at North East London Foundation Trust will be informed that I am participating in this study.	☐
• I agree to take part in the above study.	☐

For the statements below, please respond with Yes (✓) or No (✗)

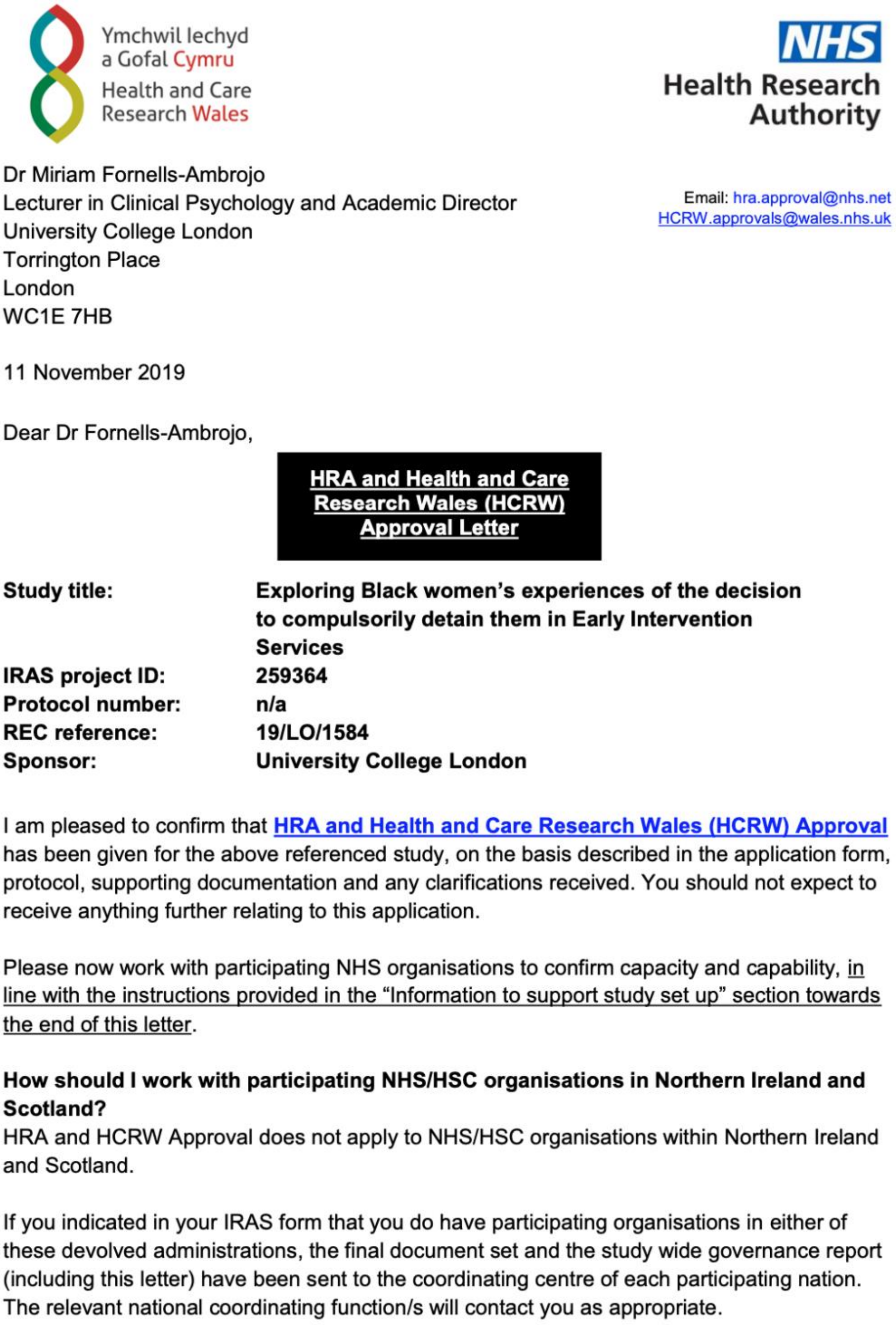
- I give consent for my GP to be informed that I am participating in this study. ☐

- I agree to be contacted by the research team for participation in:
  1. In other stages of this study ☐
  2. Follow-up studies ☐
  3. Future projects that I may be eligible to participate in ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

Appendix 9: Research Ethics Committee approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Miriam Fornells-Ambrojo
Lecturer in Clinical Psychology and Academic Director
University College London
Torrington Place
London
WC1E 7HB

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

11 November 2019

Dear Dr Fornells-Ambrojo,

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

Study title: **Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services**
IRAS project ID: **259364**
Protocol number: **n/a**
REC reference: **19/LO/1584**
Sponsor: **University College London**

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

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

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

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

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

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

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

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

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **259364**. Please quote this on all correspondence.

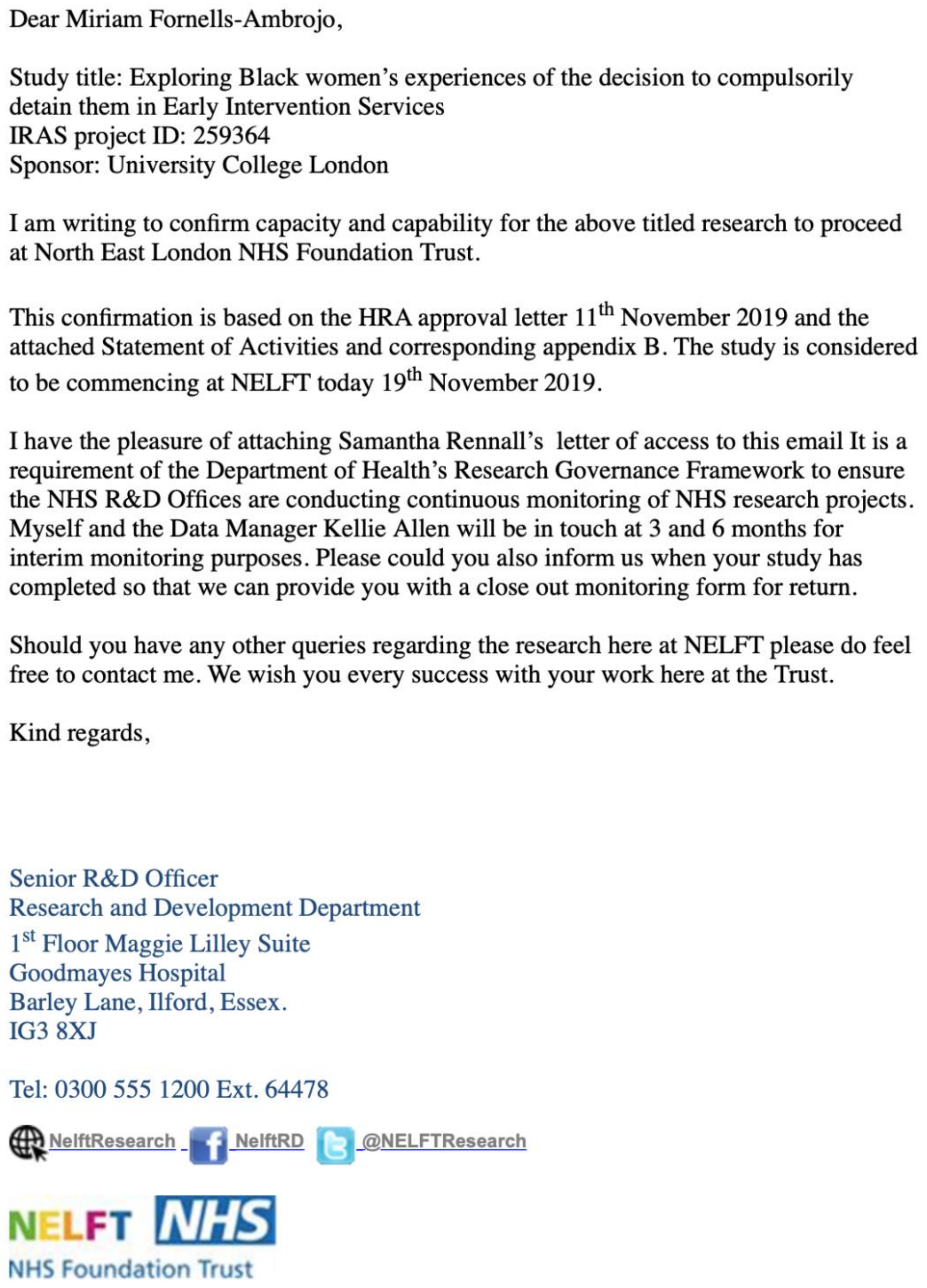
Yours sincerely,

Approvals Manager

Email: hra.approval@nhs.net

Copy to:
Dr Samantha Rennalls

Appendix 10: NHS Trust R&D approval



Dear Miriam Fornells-Ambrojo,

Study title: Exploring Black women's experiences of the decision to compulsorily detain them in Early Intervention Services
IRAS project ID: 259364
Sponsor: University College London

I am writing to confirm capacity and capability for the above titled research to proceed at North East London NHS Foundation Trust.

This confirmation is based on the HRA approval letter 11th November 2019 and the attached Statement of Activities and corresponding appendix B. The study is considered to be commencing at NELFT today 19th November 2019.

I have the pleasure of attaching Samantha Rennall's letter of access to this email It is a requirement of the Department of Health's Research Governance Framework to ensure the NHS R&D Offices are conducting continuous monitoring of NHS research projects. Myself and the Data Manager Kellie Allen will be in touch at 3 and 6 months for interim monitoring purposes. Please could you also inform us when your study has completed so that we can provide you with a close out monitoring form for return.

Should you have any other queries regarding the research here at NELFT please do feel free to contact me. We wish you every success with your work here at the Trust.

Kind regards,

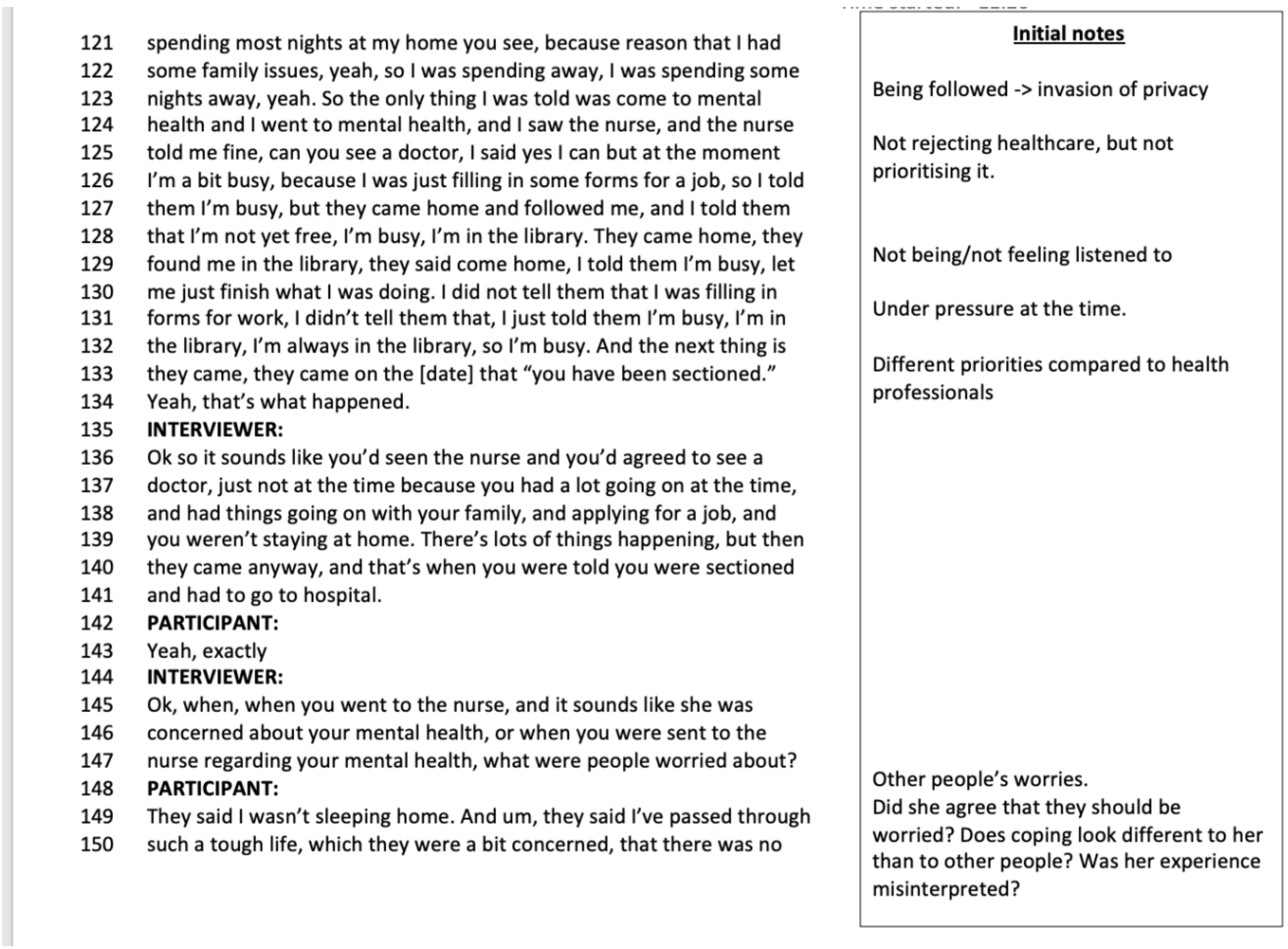
Senior R&D Officer
Research and Development Department
1st Floor Maggie Lilley Suite
Goodmayes Hospital
Barley Lane, Ilford, Essex.
IG3 8XJ

Tel: 0300 555 1200 Ext. 64478

NelftResearch NelftRD @NELFTResearch

NELFT NHS
NHS Foundation Trust

Appendix 11: Example of initial noting (analysis step 2)



spending most nights at my home you see, because reason that I had some family issues, yeah, so I was spending away, I was spending some nights away, yeah. So the only thing I was told was come to mental health and I went to mental health, and I saw the nurse, and the nurse told me fine, can you see a doctor, I said yes I can but at the moment I'm a bit busy, because I was just filling in some forms for a job, so I told them I'm busy, but they came home and followed me, and I told them that I'm not yet free, I'm busy, I'm in the library. They came home, they found me in the library, they said come home, I told them I'm busy, let me just finish what I was doing. I did not tell them that I was filling in forms for work, I didn't tell them that, I just told them I'm busy, I'm in the library, I'm always in the library, so I'm busy. And the next thing is they came, they came on the [date] that "you have been sectioned." Yeah, that's what happened.

INTERVIEWER:
Ok so it sounds like you'd seen the nurse and you'd agreed to see a doctor, just not at the time because you had a lot going on at the time, and had things going on with your family, and applying for a job, and you weren't staying at home. There's lots of things happening, but then they came anyway, and that's when you were told you were sectioned and had to go to hospital.

PARTICIPANT:
Yeah, exactly

INTERVIEWER:
Ok, when, when you went to the nurse, and it sounds like she was concerned about your mental health, or when you were sent to the nurse regarding your mental health, what were people worried about?

PARTICIPANT:
They said I wasn't sleeping home. And um, they said I've passed through such a tough life, which they were a bit concerned, that there was no

<u>Initial notes</u>

Being followed -> invasion of privacy

Not rejecting healthcare, but not prioritising it.

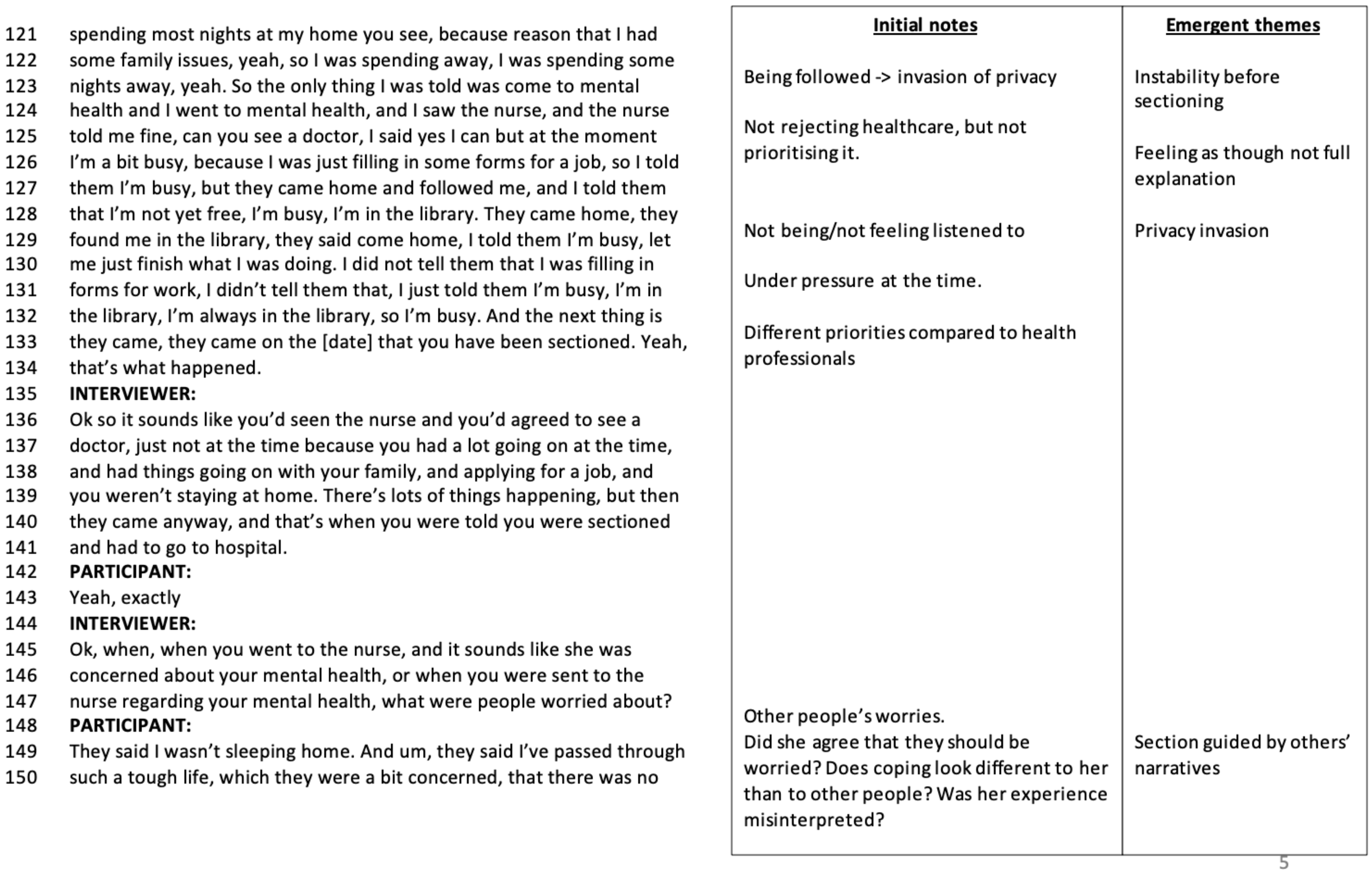
Not being/not feeling listened to

Under pressure at the time.

Different priorities compared to health professionals

Other people's worries.
Did she agree that they should be worried? Does coping look different to her than to other people? Was her experience misinterpreted?

Appendix 12: Example of developing emergent themes (analysis step 3)



spending most nights at my home you see, because reason that I had some family issues, yeah, so I was spending away, I was spending some nights away, yeah. So the only thing I was told was come to mental health and I went to mental health, and I saw the nurse, and the nurse told me fine, can you see a doctor, I said yes I can but at the moment I'm a bit busy, because I was just filling in some forms for a job, so I told them I'm busy, but they came home and followed me, and I told them that I'm not yet free, I'm busy, I'm in the library. They came home, they found me in the library, they said come home, I told them I'm busy, let me just finish what I was doing. I did not tell them that I was filling in forms for work, I didn't tell them that, I just told them I'm busy, I'm in the library, I'm always in the library, so I'm busy. And the next thing is they came, they came on the [date] that you have been sectioned. Yeah, that's what happened.

INTERVIEWER:

Ok so it sounds like you'd seen the nurse and you'd agreed to see a doctor, just not at the time because you had a lot going on at the time, and had things going on with your family, and applying for a job, and you weren't staying at home. There's lots of things happening, but then they came anyway, and that's when you were told you were sectioned and had to go to hospital.

PARTICIPANT:

Yeah, exactly

INTERVIEWER:

Ok, when, when you went to the nurse, and it sounds like she was concerned about your mental health, or when you were sent to the nurse regarding your mental health, what were people worried about?

PARTICIPANT:

They said I wasn't sleeping home. And um, they said I've passed through such a tough life, which they were a bit concerned, that there was no

<u>**Initial notes**</u>	<u>**Emergent themes**</u>
Being followed -> invasion of privacy	Instability before sectioning
Not rejecting healthcare, but not prioritising it.	Feeling as though not full explanation
Not being/not feeling listened to	Privacy invasion
Under pressure at the time.	
Different priorities compared to health professionals	
Other people's worries. Did she agree that they should be worried? Does coping look different to her than to other people? Was her experience misinterpreted?	Section guided by others' narratives

Appendix 13: Example of searching for connections (analysis step 4)

Figure 3: The process of arranging emergent themes into clusters. Each piece of paper has on it an emerging theme and associated extract from the transcript

Appendix 14: Example of theme clusters with extracts (analysis step 4)

High stressors before being sectioned		
1. Life pressures at time of sectioning	4.119	Well at the time, there was so much going on around me
2. Instability before sectioning	4.120 – 5.122	so literally I wasn't spending most nights at my home you see, because reason that I had some family issues
6. Family circumstances/separation affecting wellbeing	6.176-177	I only used to feel low because I've been away from my children, so I used to feel low
7. Being abandoned/left by others	7.194-195	Yeah, she came here to do her degree but she decided I'm going back because of the other two, so she went back
8. Under stress at time of section	8.221	Yeah, a lot of stress, a lot of stress
9. Unstable environment	8.226-228	Well I was just…livig in different areas, sometimes my friends, sometimes I would go to the airport, spend two nights there, there's a hotel there.
10.Unsafe at home	8.237	I was at home but there was so much abuse in that home.
Other people influencing decision to section		
5. Section guided by others' narratives	5.149-150	They said I wasn't sleeping home. And um, they said I've passed through such a tough life, which they were a bit concerned

45. Assumptions about capacity leading to poor treatment	18.525-526	all they do is treat you like a, like a mad person who they've come across, picked up in the streets, that's how they treat you
58. Others' narratives led to sectioning	23.674-676	they think oh my ment...there must be something wrong with me because the pressures were too much, what I went through was just too much, it's unbearable, and all that.
64. Other people influences sectioning decision	25.739-741	they must have went and complained and said "this is what she is doing, she is doing, we are thinking she wants to do a, b, c, d".
75. Lack of trust in others	30.882-883	Probably the one who is even laughing with you is the one who told them, so I don't know
77. Decision for section felt personal, not professional	31.898-900	, obviously it feels bad because some people wouldn't take it on a professional level, they just take it on a jealous level, or maybe hate for you
Sectioned as unjustified/deception in the process		
3. Feeling as though not full explanation	5.123-126	So the only thing I was told was come to mental health and I went to mental health, and I saw the nurse, and the nurse told me fine, can you see a doctor, I said yes I can but at the moment I'm a bit busy
19. Sectioning felt unjustified	10.281-283	You are going to hospital, you've been sectioned. I told them no, I don't know what you're talking about, what's the problem, what is this all about mental health?
26. Feeling as though was compliant/sectioning feeling unjustified	11.320-321	They asked me to go to mental health and I went there so all they had to do is write me a letter, because I've never refused

Appendix 15: Example of looking for patterns across cases (analysis step 6)

Feeling vulnerable

a. Not being able to understand what was happening at time of section (because of being unwell)

    1.5 Sadness/loss associated with being unwell/sectioned

    1.6 Vulnerable at the time of sectioning

    1.7 Lack of personal narrative of the decision to section her

    1.10 Experiencing psychological absence & lack of clarity during the sectioning process

    2.1 Unable to understand the process

    3.9 Sectioning making her feel vulnerable

    4.4 Feeling vulnerable

b. Lack of transparency & explanation

    3.3 Lack of transparency prior to the sectioning process

    3.4 Lack of explanation during sectioning process

    4.3 Lack of explanation/communication

    Quote from 2 about people not explaining to her

    4.10 Shock throughout the process

c. Feeling under threat and the need for protection

    1.6 Vulnerable at the time of sectioning

    2.10 Aggression as protection and expression of frustration

2.6 Frightening experience of threatening hallucinations and paranoia while being sectioned

d. The role of hospital environment & care provision

    1.14 Feeling cared for in hospital

    2.7 Feeling trapped and abandoned

    2.9 Chaotic and uncontained environment

    2.15 Experiencing restrictions as unjustified

    4.8 Hostile care environment

Pulled through by relationships

a. Relationships with nursing team/healthcare professional

    1. 11 Feeling supported by nurses

    1.12 Valued relationships during the process

    2.8 Not trusting staff to care for her

    2.14 Staff Poor standard of care, sometimes due to lack of resources

    2.17 Not feeling valued by staff

    3.5 Criminalised for being unwell

    4.2 Valuing joyful relationships with staff/being ‘seen’ by staff

b. Relationships with peers

    (quote from 2)

    3.13 Peers as helpful and unhelpful

    4.15 Peer relationships both helpful & challenging

c. The value of being listened to & being ‘seen’ as a person/human in hospital

    1.13 Being listened to/being seen while in hospital

    2.3 Explanation and being listened to improving engagement and experience

    3.6 Feeling stripped of personal rights

    3.7 Feeling disempowered

    3.10 Listening and seeing her humanity as a key priority

    4.7 Feeling unsupported by others

    4.9 Feeling misunderstood

d. Influence/role of other people outside of hospital

    2.12 Family & home helpful for coping

    3.2 Other people betrayed her, leading to section

    Quote from 4 about mum explaining and helping