

**Experiences of adults from a Black ethnic background detained as inpatients under the  
Mental Health Act (1983)**

### **Abstract**

**Objective:** People from a Black ethnic (BE) background in England and Wales are disproportionately detained as inpatients under the United Kingdom's Mental Health Act (MHA). Qualitative research into the lived experiences of this group is sparse. This study therefore aims to explore the experiences of people from a BE background detained under the MHA.

**Methods:** Semi-structured interviews were conducted with 12 self-identified adults from a BE background who were currently detained as inpatients under the MHA. Thematic analysis was used to identify themes across the interviews.

**Results:** Four themes emerged from the interviews: 'help is decided by others, not tailored to me'; 'I am not a person - I am a Black patient'; 'mistreated or neglected instead of cared for'; and 'sectioning can be a space for sanctuary and support'.

**Conclusions and Implications for Practice:** People from a BE background report inpatient detention to be a racist and racialised experience, inseparable from a wider context of systemic racism and inequality. Experiences of detention were also discussed in terms of stigma within BE families and communities, as well as social support that appeared to be lacking outside of hospital. Systemic racism must be addressed across mental health care, led by the lived experiences of BE people.

*Keywords:* inpatient detention; racial disparity; lived experience, qualitative

### **Impact and Implications for Practice**

This study found that people from a Black Ethnic background have lived experiences of racism in inpatient detention under the UK Mental Health Act (MHA), in addition to the statistical racial disparity. Lived experiences from the study also show systemic challenges, including societal racism, stigma and access to support. These experiences are not routinely monitored, leaving a significant shortcoming in the development of policies and practices that

ensure quality of care for people from a Black Ethnic background, including in psychiatric rehabilitation services.

**Experiences of adults from a Black ethnic background detained as inpatients under the Mental Health Act (1983)**

The Government of the United Kingdom reports that people from a Black Ethnic (BE) background face disparities across all areas of life affected by public institutions, such as below average educational attainment and increased likelihood of police stops and arrests. (Race Disparity Unit, 2019). The government defines this group as those who identified as Black, Black British, Caribbean or African in the 2011 Census question regarding 'ethnic group'. It does not provide an accompanying definition of ethnicity and it is recognised that these groups are not wholly representative or homogenous. Despite numerous policies and initiatives, these structural inequalities have persisted and represent a failure in the protection and promotion of human rights for BE people (Joint Commission on Human Rights, 2020). One of the largest ethnic disparities is that adults from a BE background are more than four times more likely to be detained under the Mental Health Act (MHA; 1983), when compared to people from a White British background (NHS Digital, 2021). This has been highlighted by the UK Government's Independent Review of the Mental Health Act 1983, as well as by academic research and the regulatory body for inpatient services (Department of Health & Social Care, 2018; Barnett et al., 2019; Care Quality Commission, 2020). The independent review described longstanding and complex factors associated with the detention of people from a BE background, with particular reference to systemic issues and racism. Indeed, the chronicity and severity of this inequality arguably meets the definition of institutional racism (McKenzie & Bhui, 2007; Fernando, 2017).

Research into inpatient detention for the general population emphasises the importance of staff relationships, autonomy, safe spaces and the avoidance of coercion and

restrictive practices (Akther et al. 2019; Staniszewska et al., 2019). However, such research is limited in its account of ethnicity. A recent meta-analysis specifically addressed ethnicity and identified explanatory factors for the over-representation of Black, Asian and Minority Ethnic adults in detention figures (Barnett et al., 2019). These included prevalence of psychosis, poor adherence to treatment, delayed help seeking, poor social support, perceived risk of violence, police contact, absence of general practitioners, perceptions of illness and services, racial bias in treatment, ethnic disadvantages and societal racism. This data provides significant detail, though is limited in its understanding of how detention is experienced by BE people themselves.

Service user-led organisations such as the National Survivor User Network (2018) and the Race Equality Foundation (2021) emphasise the importance of understanding the lived experiences of detention for people from a BE background. They especially recommend that such experiences are used to develop appropriate services which are informed and led by BE people. Qualitative research involving participants with lived experience is crucial to mental health care and has already provided valuable insights into detention under the MHA (Akther et al., 2019). Psychiatric rehabilitation in the United Kingdom occurs across community-based and inpatient services, as well as dedicated rehabilitation wards. The MHA itself specifically defines rehabilitation and specialist mental health habilitation as justification for detention. The current study aims to explore the lived experiences of adults from a BE background who have been detained as inpatients under the MHA.

## **Methods**

### **Participants**

Eligible participants were English-speaking adults who self-identified as being from a BE background and who were currently detained as inpatients under the MHA. The researchers aimed to recruit between 6 and 15 participants according to recommendations for

research of this scope and nature (Terry et al., 2017). Recruitment of the sample took place between September 2019 and January 2020 in one provider Trust in the South East of England. Five acute mental health inpatient wards were identified and four were able to take part. The wards were separated by gender (2 male, 2 female) but all were for adults who were experiencing acute psychiatric problems or who were in crisis. These were not specifically rehabilitation wards, but they did provide rehabilitation and specialist mental health habilitation pursuant to the MHA. Participants were excluded if they did not speak English or were detained in any other setting, such as child and adolescent, learning disability or forensic wards, due to additional medical and legal factors associated with these populations.

### **Procedure**

The research team consulted with a BE service user researcher to inform the research procedure. Firstly, posters and information sheets were placed in the wards inviting people to express their interest in participating. Those who did were subsequently approached by the lead author to discuss the study and obtain informed consent. Participants could be recruited at any time during their detention and so some were likely to be experiencing acute psychiatric illness or crisis. To dismiss the credibility of such participants on this basis risks harmful discrimination (Carlsson, 2019), therefore capacity to participate was assessed by ward staff and informed consent was sought by the lead author before proceeding. An interview was then arranged in liaison with ward staff, with a suggested time of 45-60 minutes. At the beginning of the interview, demographic information was taken and by the lead author, with an opportunity for participants to ask any further questions. The research followed the Consolidated Criteria for Reporting Qualitative Research (COREQ).

### **Materials**

Semi-structured interviews were conducted and audio-recorded by the lead author, following a topic guide. The topic guide was developed from previous research and covered: circumstances surrounding detention (Chambers et al., 2014); the experience of admission under detention (Loft & Lavender, 2016); experiences of compulsory treatment (Gault, 2009); demographic information (Hughes et al., 2009); and views on the appropriateness of detention (Katsakou et al., 2012).

### **Ethics**

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by the University of Essex, and received a favourable ethical opinion from the South East Scotland Research Ethics Committee 01 and the Health Research Authority (REC Reference: 19/SS/0068, IRAS Number: 246612). Written informed consent was obtained from all subjects/patients. Ethical considerations included: informed consent, right to withdraw, confidentiality, anonymity, data management, protection from harm, debriefing, giving advice, financial remuneration, risk awareness and formal ethical review.

### **Data Analysis**

Thematic analysis (Terry et al., 2017) was used to identify themes across the transcripts of 12 interviews. This included checks for consistency, balanced analysis and coherent reporting. Thematic analysis can be particularly useful for qualitative research in healthcare settings and with minority groups to draw out in-depth understandings of service user experiences (Braun & Clarke, 2013; Braun et al., 2014; 2015). The analysis took an inductive approach, allowing themes to emerge from the data without restraints of existing

theory or methodologies. The lead author led the analysis and discussed and reviewed themes with the second and third authors.

### **Quality Assurance**

Quality assurance measures were taken to ensure credibility, transferability, dependability, confirmability and authenticity (Denzin & Lincoln, 2011). This included feedback on the themes from a BE service user and one participant. Researcher reflexivity was also used to enhance quality assurance. The lead author kept a reflexive journal throughout the research, which facilitated consideration of their potential areas of bias as well as their overall approach to the research. The lead author is from a different minority ethnic background to the participants and did not have experiences of being detained under the MHA. This reflects an ongoing disparity in the power of researchers and research participants.

### **Results**

A total of 20 people across the four wards expressed an interest in taking part in the study. Of these, 7 participants (3 male and 4 female) changed their minds after 24 hours and 1 (male) withdrew after giving consent. The reasons given included concerns about confidentiality and involvement of the provider Trust, particularly with respect to being audio-recorded. Practical availability was also a barrier, amidst other demands and interests on the ward. The interviews lasted between 12 and 48 minutes. The mean interview time was 29 minutes and 32 seconds. Table 1 summarises the demographic and clinical characteristics of the 12 participants. Four major themes emerged from the data: Help is decided by others, not tailored to me; I'm not a person - I'm a Black patient; Mistreated or neglected instead of cared for; Sectioning can be a space for sanctuary and support. Verbatim quotes from the participants are presented to reflect the themes.

#### **Help is decided by others, not tailored to me.**

The process of being detained was described by participants as lacking choice and not what they felt they needed. Though a need for help was acknowledged, participants describe being denied access to the support that they wanted and forced into help as it was defined by others. This included experiences of seeking help when vulnerable and receiving unhelpful responses from primary care and social services.

Months ago when I approached my General Practitioner<sup>1</sup> and I said to him that I was feeling depressed, I should have got help then. Rather than when it becomes too late, so that's where I feel I've been let down..., I think, at that time, I feel he should have taken it more seriously. (Participant 7)

If [the detaining psychiatrist is] forcing me to live, give me the means, or get me a job and get me a decent place to wake up in the morning, from there. And how do I apply for a job and everything living in the field? ... Every day I cry that I'm alive because I'm just always think... I need to die, I need to die... Maybe I could have lived if you've given me the responses. (Participant 3)

Participants also reported a sense of betrayal by their families when they instigated police involvement. This was strongly felt to be unwarranted and unjust, not least due to accompanying experiences of restraint and antagonization.

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

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<sup>1</sup> The equivalent of a Primary Care Physician or Family Doctor in other territories



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

Decisions such as those about detention and diagnosis were experienced as presumptive, punitive and discriminatory, with reports that professionals did not tailor their care to participants' experiences.

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

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

### **I'm not a person - I'm a Black patient**

The second theme is a quote from one participant and brings together reports of how various aspects of a participants' experience of detention were linked to their ethnicity. This was described as an additional component to the experience of being detained, with participants reporting abuse and discrimination associated with their ethnicity. Participants did not always specify who they experienced this from, however patients, staff and society as a whole were identified or mentioned in the same passages.

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

I mean we all know, there's no point kidding ourselves, this is generally a racist country... from my experience of fifteen years of having a mental illness. Being black, you are treated as if you're superhuman, you've got superhuman powers... you just get treated differently because you're black. They [staff] assume because you're black that you're stronger... you can take it. (Participant 2)

That's a racial thing. The less, the least of us on the street, the better. Especially the men. That's what I think. I think they want it. I think they get us in, drug us up, some of us never come back... That's what I think, it's racial. (Participant 6)

Discriminatory behaviour experienced by participants was not limited to people from White ethnic backgrounds. Some participants highlighted that BE staff members could be obstructive as well as empathetic. Additionally, some participants described how BE families and communities stigmatise mental illness and detention.

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

To be that girl sectioned, [people in the Black community say] 'She was sectioned, she's mad'. I'm not mad... I think in regards to being Black...and being sectioned, I think there's less understanding in our community. (Participant 7)

### **Mistreated or neglected instead of cared for**

All participants associated the experience of detention as being at odds with their sense of normal life and their basic human rights. Participants described detention as being something that should not be happening in the way that it does, because it compromises freedom and justice. As a result, participants often compared detention to being treated inhumanely, like an animal in prison.

I felt like I was being treated like an animal. I wasn't allowed to go outside, I wasn't allowed to have fresh air. (Participant 10)

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

As well as access to outside space and the ability to smoke, participants specifically referred to negative experiences of excessive restraint and coercion as part of detention, both medical and physical.

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

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

Staff were described as either caring and overworked or otherwise directly neglectful. Some reported benign delays and obstructions, while others felt that staff were aggressive and excluded them from decisions about their care.

I noticed a lot of inefficiencies in terms of the workforce, and this is not a criticism, it's just an observation. (Participant 1)

I find staff really helpful... They're really caring. They're... really stretched, they do their best... I find the staff [that are] overstretched... to be quite aggressive. (Participant 2)

They didn't even allow me in my ward round. How would you feel about that? You'd be unhappy right?... Who wants their destiny to be decided without them there?

(Participant 8)

### **Sectioning can be a space for sanctuary and support**

Despite participants describing detention as inhumane and racialised, some did describe more positive experiences. Participants reported being able to do things that they needed to do, or avoiding things that were causing them distress. Rather than being identified as part of any specific intervention from services, this was discussed as a byproduct of being in psychiatric rehabilitation services. The positive experiences described related to forms of social or welfare support that might otherwise be provided within a community setting. This included the provision of basic necessities, such as food, as well as social support through welfare and peers.

The food (laughs). I can tell you three times a day, food. Breakfast, lunch, dinner...

[But] Instead of recovering, it is eating, sleeping and pooping and basically, just getting the body well, but the spirit, the mind and soul is not healed. In fact, actually more damaged. (Participant 10)

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

You can be around other people who are going through the same stuff as you, so you don't feel... awkward about saying, 'Oh I felt like killing myself' or 'I had these thoughts yesterday'. So you got people who's going through the same experience. (Participant 6)

### **Discussion**

The current findings broadly support previous research which details a complex mixture of experiences of detention for adults overall, ethnicity notwithstanding. The aforementioned systematic reviews outlined experiences of detention that incorporated poor communication, coercion, restraint, comparisons to prison, neglect, dehumanisation and the importance of staff relationships (Akther et al. 2019; Staniszewska et al., 2019). Although

ethnicity was not systematically reviewed in these works, their findings correspond to themes in the current research with some identical descriptions, such as detention being like prison. This suggests that there may be universal experiences of detention that people have in common regardless of ethnicity.

The current research nevertheless adds unique findings relating to ethnicity, reflecting rich and varied experiences from BE participants who reported racism and discrimination, unwarranted involvement from family, police and professionals, and difficulty in accessing support. These findings reflect issues highlighted by the Race Equality Foundation and the systemic review of ethnic variation in detention, both of which described how societal racism, police involvement and access and engagement with services were prominent factors in the detention of BE people (Barnett et al., 2019; Bignall et al., 2019). These findings are also consistent with themes from previous research with BE people and their carers, where data were collected retrospectively after detention rather than contemporaneously as in the present study (Keating & Robertson, 2004). Overall, data from the current research indicates that for BE people, experience of detention is likely to be affected by ethnicity, sometimes mirroring experiences of racism in wider society. This further supports statements from the independent review, which highlight a number of systemic factors relating to ethnicity. The findings also appear to reflect previous identification of institutional racism in mental health care (McKenzie & Bhui, 2007; Fernando, 2017), given that participants reported system-wide negative experiences of processes, attitudes and behaviours in relation to their ethnicity.

### **Implications and Recommendations**

The current research shows that adults from a BE background who are detained under the MHA experienced racism and racialisation as part of their detention. Previous reports suggest that BE people expect unequal treatment from health services and are less likely to raise concerns about their mental health care (Joint Commission on Human Rights, 2020; Care

Quality Commission, 2019). The current research may therefore provide insight into patient experiences that are not being identified in current quality and safety review systems. Indeed, although racism towards staff is routinely reported, there are no such reports for patients (NHS, 2020). One implication may be for regulatory bodies to monitor racist and racialised experiences in psychiatric rehabilitation services more directly, with consideration of how existing channels to report incidents in these settings may be underused by BE people.

In addition to better monitoring, a further recommendation is to go beyond transcultural care and instead make psychiatric rehabilitation services explicitly anti-racist. Recommendations for this were recently outlined by summarising 30 years of research into 36 guidelines, including having an awareness of the impacts of racism on mental health and using psychotherapies that have been shown to be effective in Black communities (Cénat, 2020). Addressing racism in wider society is not straightforward and beyond the scope of these findings. However, it is nevertheless crucial to acknowledge the societal determinants of health that exist outside of psychiatric rehabilitation services (Race Equality Foundation, 2021). Both current and previous governments have published commitments to acknowledge and address this, though subsequent scrutiny of these pledges highlight a chronic lack of change (Joint Commission on Human Rights, 2020; Health and Social Care Committee, 2021).

Participants further discussed their experiences of detention with respect to their families and communities. This incorporated stigma around mental health and detention amongst BE people, as well as police involvement instigated by family members. This has implications for carer involvement in severe mental illness and particularly decisions around detention. Overall, these findings again represent the need to take a systemic view of psychiatric rehabilitation, in this case addressing the way that, families, communities and the police are involved. This has emerged as a recommendation from the independent review to comply with existing policies and procedures regarding equality, as well as pledging new

commitments in this vein. It outlines a Patient and Carer Race Equality Framework to ensure culturally appropriate advocates, higher thresholds for compulsory psychiatric care and seeking greater representation of people from a BE background in key professions. These initiatives are currently being piloted.

Although participants did not explicitly discuss this in association with ethnicity, they described an overall lack of access to mental health care at the point of need, as well as a lack of support from other services such as social care. This was highlighted in the systemic review of ethnic variations in detention (Barnett et al., 2019) and implicates wider systemic issues which include perceptions of services, delayed help seeking, and racial bias in treatment. The current findings therefore suggest that difficulties accessing and engaging with services for BE people may be a combination of challenges from services as well as communities. The recommendation is therefore to collaborate with multiple systems that impact on psychiatric rehabilitation services for people from a BE background. Some ways of working towards this have been highlighted by the Race Equality Foundation (2021) and include engagement with carers, voluntary organisations, community-based services, social enterprises and faith groups.

Finally, the current findings demonstrate the value of qualitative research regarding lived experiences, particularly with respect to people who are marginalised. This is acknowledged across service-user organisations, academic research and the independent review, as is the recommendation that more research and practice that is led by lived experiences is crucial for meaningful change.

### **Strengths and Limitations**

The findings presented in this study do not represent a comprehensive or definitive account of BE experiences of detention, given the qualitative nature of the research and the relatively small sample. Instead, it serves as an in-depth exploration of a number of individual experiences within one Provider Trust in one locality, which may be unique in a number of

ways, not least ethnic demographics. In particular, the locality is a densely populated urban area with relatively high ethnic diversity where experiences of BE participants may be influenced by ethnic density. The sample was also heterogenous in terms of diagnosis, detention length and ethnicity and the findings should be considered transferrable rather than generalizable. Moreover, the wards from which participants were recruited were not dedicated psychiatric rehabilitation wards, but acute inpatient wards which offered rehabilitation. It may not therefore be possible to take make direct recommendations for rehabilitation wards, but rather for psychiatric rehabilitation across the mental health system.

Notably, there was a minority of males in the sample, which does not reflect the over-representation of males in national MHA statistics. This therefore limits the transferability of the findings to some extent, with no obvious explanation offered. The Race Equality Foundation highlights how BE men may be particularly reluctant to access and engage with mental health care, partly due to stigma (Bignall et al., 2019). It is possible that this extends to engaging with mental health research, but this is conjecture. The current research offers no further insights into this from the small sample of males interviewed and this is a significant limitation considering the higher proportion of BE males detained under the MHA.

Nevertheless, the findings still contribute to an understanding of how ethnicity impacts on experiences of detention among BE adults. The findings reflect the lived experiences of people from a BE background, which enhances the interpretation of quantitative data in this area. Although interviews were shorter than expected, it was nevertheless possible to collect rich data relating to the research aim. Methodological rigour was prioritised through a number of processes to ensure credibility, transferability, dependability, confirmability and authenticity (Denzin & Lincoln, 2011). This included, but was not limited to, checking the analysis with a participant, consulting a BE service user researcher, transparency with the research procedure, systematic analysis and reflexivity by the first



author throughout. As a result, a key strength of the study is that it presents an account of lived experiences which have been subjected to quality assurance.

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### **Data Availability Statement**

The data that support the findings of this study are available on request from the lead author. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

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