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NIHR Policy Research Programme Project:

Improving the Experiences of Black African Caribbean Men Detained Under the Mental Health Act: Co-Produced Policy and Practice Recommendations for Change and Reform (ImproveAct)

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Lay Summary

"I can't breathe" is the cry uniting the Black Lives Matters movement aiming to highlight racism, discrimination, and racial inequality experienced by Black people. Its primary concerns are unwarranted police brutality and racially motivated violence against Black people; all of which are experiences Black African Caribbean (BAC) men have reported whilst being detained under the Mental Health Act. BAC men are 4 times more likely to be detained than non-Black men. They experience racist, inhuman practices that are unfair, discriminatory, and traumatic to them and their families. This research aimed to work with the BAC men and their communities to co-produce practice and policy recommendations that could improve their experiences of detention and mental health services.

To do this, we used 2 co-production methods (1) The Silences Framework and (2) Experience Based Co-Design to listen to 10 people/carers who have been through detention experiences and 13 professionals working in the detention field. We then brought together over 200 people (including people with lived experience, police, health and social care professionals, Government workers, policy makers) to co-produce solutions to these problems.

These methods gave a voice to the men that are not yet found in research. Their stories are often silenced, pushed down or not told because of fear they will be used against them. Using music, poetry, and art-based techniques we created a safe space for men to share their accounts for the first time.

Our 3 themes found that practitioners need to see beyond the race of BAC men and understand them through the lenses of spirituality, stigma, and the traumatic effects of racism. To re-humanise detention, we need to acknowledge and address power imbalances, misconceptions, and injustices BAC men currently experience when being detained. Developing a BAC cultural, recovery focused assessment, care and support model for and with BAC men and their communities will radically reform the out-of-date Mental Health Act. We created 8 considerations for policy and practice that offer suggestions how to solve some of these problems.

Executive Summary

Introduction

This research aimed to understand the experiences of Black African-Caribbean (BAC) men, addressing the reasons why they are disproportionately over-represented and detained under the Mental Health Act (1983) (MHA). This disproportionate use highlights systemic issues within the wider mental healthcare system that urgently requires reform. Over the past four years, Manchester Metropolitan University and Policy Connect have collaborated with individuals affected by the Act, professionals involved in the detention process, third sector, community pillars, and policy makers to explore areas for improvement.

Study Aims and Objectives

Aim: to inform, develop and co-produce practice and policy recommendations for approaches to improve the experiences of Black African Caribbean (BAC) men detained under the Mental Health Act

Objectives:

- To co-develop an authentic and fully integrated patient and public involvement (PPI) strategy that will drive the project throughout;
- To develop and deliver a strong policy impact work package and consult with policy stakeholders to inform and produce recommendations for service improvement and policy action;
- To identify existing evidence regarding the issues that lead to over-representation of BAC men detained under the MHA and interventions currently used to address this;
- To explore the experiences of the 'mental health detention' journey of BAC men and their significant others;
- To explore the views of professionals involved in the detention process and identify key areas for improvement/intervention goals; and
- To co-produce recommendations to inform policy and practice.

Methods

This research used the Silences Framework (TSF) (Serrant-Green, 2011) as an overarching theoretical framework and Experience-based co-design (Bate and Robert, 2006) as a key participatory action research method. Two research studies were conducted: (i) a systematic review and (ii) an EBCD study. Co-production with stakeholders and policy engagement was incorporated across all stages of the research.

The systematic review was conducted using the NIHR systematic review protocol, was registered with Prospero (CRD42022274045) and reported using PRISMA guidelines. A qualitative thematic appraisal was conducted on the 34 included papers. Throughout the systematic review process, people with lived experience explored the Silences in the literature and co-developed the key findings and recommendations of the review. The 'Silences' are areas of both literature and experience which are under researched and therefore, lack understanding. Silences often reflect the unsaid or unshared aspects of how beliefs, values and experiences of (or about) some groups affect their health and life chances. Uncovering these often expose issues which shape, influence and inform both individual and group understandings of health and health behaviour (Serrant-Green, 2011).

The EBCD study was approved by Health Research Authority (IRAS ID 310503) and participation was subject to consent. Thematic analysis (Braun and Clarke,2021) and methodological triangulation (Noble and Heale, 2019) were used to analyse and synthesise data collected using a wide range of methods, e.g., 1:1 in depth qualitative interviews and

workshops with professionals involved in the detention process; focus groups and community based creative workshops with BAC men, family members and BAC community pillars; and a co-design event bringing together a wide range of stakeholders.

Key findings

Three ImproveAct main themes:

1. ***Identities Beyond the Mask***: seeking to understand the identity of the Black man through the lenses of spirituality, stigma, and racism;
2. ***Re-Humanising Detention***: addressing the systemic imbalances of power, misconceptions, and injustices currently operating within the whole detention process; and
3. ***Radical Reform***: working towards a more equitable and inclusive Mental Health Act for all by unpacking mental health care, treatment, and medication.

These themes highlight that mental health practitioners need to see beyond the monolithic racialised mask of BAC men and understand their identity through the lenses of spirituality, stigma, and the traumatic effects of racism to re-humanise the detention process. This requires putting the person before the practice.

To re-humanise detention, we need to acknowledge and addresses the systemic power imbalances, misconceptions, and injustices currently operating within the detention process dictated by the out-of-date Mental Health Act. “It will take all colours to get out of this and work together for systemic change” argued one research participant.

Eight ImproveAct Key Policy and Practice Considerations:

1. ***Develop a community-led multi-agency independent advisory group to address detention-led inequalities for BAC people and racism***: the advisory group would include faith leaders and key community pillars, people with lived experience and their significant others, professionals involved in the detention process, representatives from the local authority and integrated partnerships.
2. ***Develop cultural appropriate/humility training***: the culturally appropriate training must be underpinned by cultural humility; this is not just a learning exercise of another person’s culture but understanding that our western dominated mental health system/beliefs are a source of this imbalance of power.
3. ***Develop ‘Go to Mental Health Hubs’ in the community***: the hubs would encourage a shift from a medicalised model of support to a community based, safe space; they would encourage conversations in the community about mental health before it gets to crisis; they could be the first point of call/referral to counselling, peer and mentorship support.
4. ***Enable advocacy, rights and complaints***: there is a need for culturally appropriate advocacy in Mental Health trusts, so that patients can challenge disagreements in assessments or support delivered, as well as decision making regarding medication.
5. ***Rebuild trust between the police and the BAC community***: police training needs to include the voice of people with lived experience and their significant others. This includes creating police training to improve awareness regarding distress related presentations (e.g., PTSD), as well ways to de-escalate and avoid using restrictive practices.
6. ***Shared decision making and person-centred care***: there is a critical need to re-distribute the power by involving people in their care in a meaningful way (to them); this means both patients and their significant others. Treatment options should

include more choice for creative interventions and psycho-social/non-pharmaceutical interventions.

7. ***Reform the mental health assessment process***: there is a need to reform the processes used and develop culturally appropriate tools/interventions with and by BAC communities, researchers, practitioners. There is a need to provide more time for mental health assessments during the detention process.
8. ***Medication***: there is a need for a transcultural system for administering psychiatric medication using evidence from studies/trials focusing on BAC men. This should include access to an independent, culturally trained pharmacist, advice and information independent from the ward.

Conclusions and recommendations for further research:

The ImproveAct project used an adaptive approach and authentic community engagement to co-produce a balanced understanding of the issues BAC men face in mental health services, co-developing findings and recommendations for policy and practice change. The three ImproveAct themes highlight and represent the current systemic problems with the detention process whilst the eight considerations for policy and practice offer co-produced solutions and recommendations to these problems.

Emerging findings are not new and they mirror the Mental Health Act's White Paper Reforms (2021). The fact that we get the same messages again and again points to an urgent and final call for action. Together we have shown that every colour is needed to re-humanise the detention experience and radically reform the Mental Health Act.

Further research should be commissioned in order to:

i. develop appropriate methodologies to both engage with underserved communities and capture the lived experience of a community rather than focusing only on individual stories; this includes developing and implementing ethical procedures that are accessible, non-jargonistic, as well as funding and academic systems enabling meaningful participation from people with lived experience, specifically from people on benefits;
ii. develop community-based, community-led therapeutic interventions that tackle generational and community trauma and racism (e.g., art-based, creative methods); and
iii. explore and better understand the linkbetween psychosis and spirituality to help clinicians with decision making, especially regarding detention and diagnosis.

Dissemination Plans and Expected Influence:

The ImproveAct project has been successful in generating impact via parliamentary symposiums, round table sessions, conference presentations, seminars/webinars attended by a wide range of audiences, including academics, practitioners, people with lived experience and their carers, students, and the public. Impact beyond practice and academia has also been achieved via the use of social media, blogs, and press releases. Exposure via the MentalElf has generated substantial nation-wide impact, with evidence of engagement from 106 online social media attendees who tweeted a total of 439 Tweets. Those tweets then went on to have 21.6 million hashtag impressions. The ImproveAct conference took place on the 21st May 2024. We had 105 attendees including people with lived experience, health and social care professionals who work in the detention field, third sector BAC mental health charities and advocates, legal experts, the police and mental health and racial disparity researchers. The other four studies funded under the same NIHR call were invited to share their findings also. Only the FINCH study could attend but they shared two sessions with delegates. This conference was not only educational, and informative, but it was a

creative, immersive day that showcased the BAC art, and poetry created from the ImproveAct FGs. The conference ended with a final call to action, engaging every colour, profession and experience to campaign for radical reform of the Mental Health Act.

Description of Research

1. Background

This research aimed to understand the experiences of people of Black African-Caribbean (BAC) descent, including those of mixed/dual-heritage and who self-identify as Black, or Black British, addressing the reasons why they are disproportionately over-represented and detained under the Mental Health Act (1983) (MHA). The Independent Review of the MHA (2017) noted significant gaps in relation to this group. UK Government figures show that BAC people are detained significantly more than their non-black peers under the MHA. A landmark review in 1996 suggested that BAC men were more likely to be detained, socially isolated, and have contact with the police. Since then, many studies have explored detention rates under the MHA of black and minority ethnic groups with latest evidence still indicating that BAC men are more likely to be detained in hospital or on Community Treatment Orders.

In addition, existing evidence indicates that BAC men have significant care needs, but poorer patient outcomes than 'White' groups. People from BAC communities are more likely to experience social exclusion including racial discrimination, poor socio-economic status and unemployment, all of which are risk factors for poor mental health. Different routes into mental health detention also warrant further investigation.

The views of BAC men are severely under-represented in existing research. The dominant perspectives are those of White medical professionals, policy makers and other stakeholders with little reference to the socio-cultural contexts uniting experiences of race, gender and mental health. This leads to a range of problems, such as BAC men's reluctance to engage with mental health services due to culturally inappropriate service-led responses and stereotypical views by professionals that worsen distress and mistrust. This is underpinned by a complex mix of gendered and racialised experiences such as social stigma, the coercive power of institutions, and men's own perceptions of services. This can contribute to cycles of disengagement by BAC men who distrust services due to cultural differences.

The experiences and outcomes of BAC men detained under the MHA points toward the urgent need for an approach to safeguard individuals from structural factors which engender racism, stigma and stereotyping systemic epistemic injustice and implicit bias. However, what is missingfrom research are the accounts of decision-making as a shared enterprise, which explore the diverse contexts in which BAC men live their lives. Whilst there have been previous attempts to understand the experiences of people detained under the MHA, there remains a gap in understanding that can only be filled through co-production.

Understanding the experiences of individuals from disadvantaged groups is important for the development of effective policies and procedures to improve significant health disadvantages. As it will be indicated below, the ImproveAct team have used adaptive inclusive research and community engagement approaches to co-produce a balanced understanding of the issues BAC men face in mental health services, co-developing findings and recommendations for policy and practice change.

2. Aim and Objectives

Aim: to inform, develop and co-produce practice and policy recommendations for approaches to improve the experiences of Black African Caribbean (BAC) men detained under the Mental Health Act

Objectives:

- To co-develop an authentic and fully integrated patient and public involvement and engagement (PPI) strategy that will drive the project throughout;
- To develop and deliver a strong policy impact work package and consult with policy stakeholders to inform and produce recommendations for service improvement and policy action;
- To identify existing evidence regarding the issues that lead to over-representation of BAC men detained under the MHA and interventions currently used to address this;
- To explore the experiences of the 'mental health detention' journey of BAC men and their significant others;
- To explore the views of professionals involved in the detention process and identify key areas for improvement/intervention goals; and
- To co-produce recommendations to inform policy and practice.

3. Method

To address these objectives, this research used the Silences Framework (TSF) (Serrant-Green, 2011) as an overarching theoretical framework and Experience-based co-design (EBCD) (Bate and Robert, 2006) as a key participatory action research method. TSF, and its underpinning concept of 'Screaming Silences', has been designed and used to explore subjects which are sensitive, little researched or silent from policy discourse and practice. The development of this framework stems from a study exploring the decisions and silences surrounding Black Caribbean men around 'sexual health' and 'ethnicity' issues. EBCD is a service user-orientated action research process that enables professionals and service users to co-design services, interventions, care pathways, in partnership. The Silences Framework aligned very well with EBCD approach in this study to redress existing power imbalances through a collaborative, co-production focused methodology. We sought to identify appropriate, realistic ways to improve the experiences of BAC men detained under the MHA and we realised along the way that, only through meaningful co-production, we could achieve these goals.

Two key research studies were conducted part of the ImproveAct project:

(i) A systematic review (as described in section 3.1 below) and
(ii) An EBCD study (as described in Section 3.2 below).

Co-production with stakeholders (i.e., people with lived experience, professionals involved in the detention process and policy makers) was however at the heart of our research, and incorporated across all project's stages:

- Working with people with lived experience to identify, understand, and analyse silences, gaps and ways to conduct research in an acceptable authentic way (PPI group);
- With our PPI group, co-identifying key evidence and silences (lack of evidence) through systematically searching and reporting the literature regarding the issues that lead to over-representation of BAC men detained under the MHA;
- Interviewing staff involved in the detention process to capture their views and experiences (e.g., AMHPS, ambulance staff, police officers, nurses, psychiatrists) and validating emerging findings through a feedback event;

- Adapting our research approach from 1:1 research interviews to creative informal community based events and focus groups, to engage with the community of BAC men and their significant others to better understand the failings regarding their experiences of mental health services and ways to improve them;
- Bringing together findings from the systematic review, the professionals' interviews and the group sessions with the communities of BAC men to develop emerging themes (thematic analysis);
- Bringing together all stakeholders (including those involved in the study, as research participants) at a co-design event to validate these emerging themes, identify more silences/things that were missed, as well as key recommendations/areas for improvement;
- Presenting our emerging findings to policy stakeholders and engaging in activities aiming to inform MHA reform and policy and practice in this area (Policy Connect), including a final Policy symposium where the policy recommendations were discussed and further co-produced; and
- Co-designing a social media strategy which enabled us to stream our public events live, via social media (The Mental Elf) and disseminate our emerging findings via blogs.

For an illustration of the project's approach, see ***Fig 1*** below.

Figure 1. The ImproveAct methodological and theoretical approach

•Systematic review (co-production with people with lived experience + Silences framework)

•Interviews and workshops with professionals
•Community events with BAC men and significant others
•Feedback and co-design events

Silences Framework

Experience-based co-design (EBCD)

Patient and public involvement (PPI)

Policy, public & practice impact

•Community engagement activities, people with lived experience engaged throughout

•Parliamentary symposiums and Roundtable Events (Policy Connect)
•Social media (Mental Elf)
•Dissemination events/worlshops

3.1. The systematic review

The systematic review has summarised the existing evidence on the reasons why BAC men are detained under the MHA, the pathways to detention, and reasons why they are four times as likely as White males to be detained, have lengthier compulsory hospitalisation, higher rates of seclusion, and higher doses of medication. We have synthesised the data collected from existing academic sources, and through working in coproduction with BAC males, family members and carers, professionals, and other identified people along the MHA detention pathway as appropriate to 'fill in the gaps', raising awareness of issues that may not have appeared in the literature before. It is recognised that BAC people have been consulted previously, but this has not been translated into the change that is needed in mental healthcare. Giving people with lived experience a voice has been crucial within this research, and the systematic review was able to embed the lived experience voice throughout.

3.1.1. Proposed research questions:

- What are the experiences of BAC men who have been detained under mental health legislation?
- In what context does detention under the Mental Health Act occur for BAC males occur?
- Whose voices are missing from the current evidence and what questions remain unanswered [Silences Framework]?

3.1.2. Changes to the review:

The review started before the PPI team had a chance to recruit experts by experience, and before the project administrator was hired. As some ImproveAct co-applicants were experts by experience, we utilised their knowledge, as well as the knowledge of the team as experts in the field to come up with key search terms. We also consulted the Police, and NHS librarians who modified our search teams into workable search strings. Once we had recruited people with lived experience, we held an initial workshop to showcase what the papers had found. This then led to us coming up with more search terms in co-production and conducting further searches.

During the initial stages of searching, the team decided to change some of the parameters of the searches due to knowledge we had gained through other related activities. This was to reduce the time from 1983 to 2000, and to remove words relating to crime, criminal activity, and incarceration because of crime. This helped us to reduce the focus to detention under mental health legislation.

3.1.3. Revised research question and objectives:

Research Question: What are the experiences of BAC men who have been detained under mental health legislation?

Objectives:

- To explore in what context does detention under mental health legislation occur for BAC men;
- Using the Silences Framework, identify whose voices are missing from the current evidence and what questions remain unanswered.

3.1.4. Method

In this study, we conducted a traditional systematic review, however, it was important to the team that we did not replicate what had been done countless times before. We utilised the Silences Framework to give a voice to BAC men who have been detained under mental health legislation, and their parents and carers. There is no framework for this as it has never been done before, but we believe that people with lived experience should be able to have their say to fill in the silences that are not being said within the literature to date. There are four stages (out of five) to the framework that we have included within the overarching systematic review:

<u>Stage 1. Working in silences:</u>

This stage encompassed the initial literature review. The aim of which was to understand existing knowledge on BAC men's experiences of detention under mental health legislation, while accepting that the information was likely to be imperfect. Having an in-depth understanding of previous findings created the landscape from which we could draw out the 'silences': what is unknown or unsaid about race, ethnicity, and compulsory detention. The literature review was iterative and workshops were held to understand if there was data that was missing from the initial searches. All of the authors values were considered in the reading of the data and through structured discussions, we all explored the themes in the existing literature.

Three databases were searched: EBSCO, ProQuest, and PMC. Studies were initially included if they were published from 1983 to 2022, published in English and including a specification of ethnicity (using Boolean terms) where Black, mixed heritage, African, or Caribbean is stated OR specifying the gender as male, OR specifying detention (See appendix 1 for search examples). This was to ensure all possible literature was captured, and we would limit this at the full paper stage, ensuring the papers had Black (or any associated words), male, and detention under mental health legislation, stated within their study. Exclusion criteria included papers not in English, and did not specify ethnicity, was about females only, did not include detention, and where participants were under 18 years old.

<u>Stage 2. Hearing silences:</u>

Using the Silences Framework meant that we already understood that there was information and voices missing in the data. This stage therefore involved identifying the silences within the literature and exploring where and why the silences exist. This was achieved through three workshops, a writing retreat, and multiple online and in person meetings with the research team, which included people with lived experience, practitioners, academics, and researchers. The process of hearing the silences was reflexive, and included understanding that all silences are interpretations based on one's lived experience and relationship to the subject and the research team, and therefore, ultimately subjective.

The first draft of the review was created in September 2022 at a two-day writing retreat and included six members of the research team, two of which were people with lived experience. To account for the fact that some of the researchers did not have as much experience as others in writing up a systematic literature review, and to draw on the experience of the Silences Framework method from its creator, the writing retreat was created specifically to

allow for undivided space and time to work on the first draft in a supportive, informal way to reduce any inequity that may have been felt within the team.

On day one we familiarised ourselves with the themes created from the literature review and discussed some initial silences. On day two Professor Laura Serrant, the creator of the Silences Framework, led a discussion on finding the silences within the literature. Before the end of the second day, we had created the initial structure, themes, and silences for the systematic review paper. Versions of the paper were then created collaboratively through multiple online and in-person meetings, phone calls, and emails.

Stage 3. Voicing the silences:

The analysis of the silences involved exploring them in more depth. This recontextualised our findings and brought the silences back into the 'real world' they exist within. This stage of the Silences Framework was also reflexive; the analysis of the findings was continuous and cyclical. The initial findings were presented at an international conference and at a community engagement event, attendees of both events were provided the opportunity to feedback on the silences reported allowing the research team to understand the silences from other perspectives.

For experts by experience to feel comfortable about voicing silences, we adopted a considered reflexive approach where potential sources of sensitivity were understood, identified and the potential impact considered and proactively planned for as part of the study design. Distressing topics that emerged during the formulation of the systematic review led to people with lived experience needing time away from the project and mental health support from the qualified counsellor on the team. While a counsellor was available to all those involved in the project, more robust mental health support could have been developed in collaboration with people with lived experience prior to the start of the project.

Stage 4. Working with 'silences':

The last stage of the framework (that we used) requires us as researchers to consider what happens after the project, the potential impact of the findings, and what steps can be taken to achieve the goal or aim of the project. It is important that we publish the findings, and find other ways (briefing papers, workshops, conferences, social media, etc) to showcase this work. Our co-producing people with lived experience have confided in us, shared their thoughts and emotions and as ethical researchers we need to ensure their, and our, voices are heard.

The four stages of the Silences Framework are cyclical and each stage is to be considered several times as necessary throughout the life of the research. Through adopting a Silences Framework and a truly authentic empowerment model of co-producing the research with people with lived experience, (in this case, BAC people with experience of detention under mental health legislation or caring for somebody who is, or has been detained) we collectively and continually questioned what was missing from the research.

3.1.5. Analysis of review findings

The analysis of the systematic review was conducted as per the NIHR framework for systematic reviews (Kim 2023). This meant that the information from the results section within each of the studies was thematised based on an initial reading by at least two members of the team per article. Themes were not predetermined as we were keen for the

people with lived experience to feel comfortable with selecting terms that were more natural to them rather than using pre-determined academic language. Adopting this method of thematising the findings led to some very open and honest conversations within the wider team. Twelve members of the systematic review team came together over two workshops to discuss the papers. As there were so many papers, we felt it was better to conduct this in two halves. Concentrating on such an emotive topic for long periods of time is very difficult, and we did not want the team to feel overly burdened. The workshops lasted for three hours each including lunch and were conducted a few weeks apart, allowing time to reflect on the previous discussions. During the workshops, each member of the team stated what they felt were the most prevalent themes and why. As the discussions progressed, we started to build overarching themes, whose names would be determined by the people with lived experience. These were given preliminary names after the first workshop, and then given more substantive names after the second workshop. These would be taken forward to a writing retreat where they would be discussed further in terms of the silences.

The two-day writing retreat took place in September 2022 and included six members of the research team, two of which were people with lived experience. To account for the fact that some of the researchers did not have as much experience as others in writing up a systematic literature review, and to draw on the experience of the Silences Framework method from its creator, the writing retreat was created specifically to allow for undivided space and time to work on the silences, and therefore the first draft of the journal article, in a supportive, informal way to reduce any inequity that may have been felt within the team. On day one we familiarised ourselves with the themes created from the workshops and discussed some initial silences. These silences involved an inordinate amount of personal reflection from the people with lived experience and was emotionally taxing. One member of the team attended in a dual role as both a researcher and as a counsellor to ensure the mental wellbeing of the core team, especially the two people with lived experienced.

On day two we met with Professor Laura Serrant, the creator of the Silences Framework, to discuss finding the silences within the literature. Before the end of the second day, we had created the initial structure, themes, and silences for the systematic review paper. Versions of the paper were then created collaboratively through multiple online and in-person meetings, phone calls, and emails.

3.1.6. Systematic Review Findings

The systematic review was conducted using the NIHR systematic review protocol, was registered with Prospero CRD42022274045 and has been reported using PRISMA guidelines (for ImproveAct review searches and PRISMA flowcharts (see *Appendices 1-2*). The searches resulted in 15,300 papers being identified, which were reduced to 34 papers for inclusion (See table 1). A qualitative thematic appraisal was conducted on the included papers. Throughout the systematic review process, people with lived experience on the review team explored the Silences that were not present in the literature and co-developed the key findings and recommendations of the review.

Table 1 Table of included studies

Lead Author and date	Country	Method	EDI Score (0=Excellent, 5=Unclear)
Alexandre 2010	Portugal	Quantitative	2
Bansal 2022	UK	Meta-ethnography	N/A
Barnes 2008	USA	Quantitative	5
Barnett 2019	Multiple	Systematic review and meta-analysis (Global)	N/A
Bhui 2003	UK	Systematic review, narrative synthesis and meta-analysis	5
Bhui 2015	Multiple	Systematic review (UK and USA)	N/A
Bolden 2005	USA	Quantitative	2
Bookle 2011	UK	Case-Control design	1
Boydell 2010	UK	Quantitative	2
Chakraborty 2009	UK	Qualitative	0
Coid 2000	UK	Quantitative	2
Commander 2003	UK	Quantitative	0
Evans 2017	UK	Quantitative	2
Halvorsrud 2018	UK	Systematic Review	N/A
Henderson 2015	UK	Quantitative	1
Keating 2004	UK	Qualitative	0
Kaselionyte 2019	Multiple	Systematic literature review	N/A
McBride 2021	UK	Quantitative	0
Mfoafo-M'Carthy 2014	Canada	Qualitative	3
Mohan 2006	UK	Quantitative	1
Oduola 2019	UK	Quantitative	2
Oluwatayo 2004	UK	Case note reviews	2
Raleigh 2007	UK	Quantitative	2
Rotenberg 2017	Canada	Quantitative	1
Saltus 2013	UK	Quantitative	3
Singh 2007	UK	Systematic Review	N/A
Singh 2014	UK	Quantitative	0
Sohler 2004	USA	Quantitative	2
Solanki 2023	UK	Qualitative	0
Valenti 2014	UK	Qualitative	2
Wanchek 2012	USA	Quantitative	3
Watson 2015	UK	Quantitative	1
Weich 2017	UK	Quantitative	3
Whaley 2004	USA	Quantitative	2

Two reviewers conducted an equality appraisal based on a previous version by Bhui et al. (2015), providing a score on how each included paper describes ethnicity, gender, and detention (table 2). This equality appraisal showcased the differences in the explanations of these demographics and therefore the difficulties involved in comparing the data. As this is not an approved measurement tool, we did not use it to exclude papers, but felt it was an important to include how vastly different demographics are recorded in healthcare, and how difficult that makes it for researchers to use the data to state anything with any certainty about equality, diversity, and inclusion issues. Systematic reviews were given a rating of N/A (not applicable) as the data was too varied.

Table 2 Ethnicity, gender, detention score

Score	Ethnicity Categorisation	Gender	Detention
2	Inappropriate ethnic groups or difficult to ascertain ethnicity. Third party categorisation, unclear.	Does not differentiate between genders	Admittance to a mental health ward/ unit/ other without specific information on compulsory detention under mental health legislation
1	BAME or BME not separated out, groups lumped together. Self-reported needs interpretation (i.e. States Black Zimbabwean and interpreted as Black African to comply with UK Gov guidelines)	Differentiates between gender	States mental health detention
0	Clear definition for Black, Black African and or Caribbean, Black mixed or Black other/ unspecified. UK Government defined categories.	Differentiates between gender and links specifically to ethnic identity, specifically Black men.	States mental health detention under legislation

Thematic analysis (Braun and Clarke, 2023) was used to bring together the quantitative and qualitative data. Three broad themes were developed taking into account both what was being said in the literature and what was not (silences): (1) contextual identity; (2) culture, spirituality, and religion; and (3) power, language, and communication. People with lived experience discussed what these themes meant to them and the results are presented as ‘Screaming Silences’ - a concept that amplifies what is known (by patients, family and friends, professionals, and others), but is not explicitly discussed within the literature. The systematic review produced several themes and over 50 subthemes (see Appendices 3). The people with lived experience on the team chose the three themes that were most prolific and important to them.

Contextual identity:

The grouping of demographic data often leads to the view of BAC males being a ‘monolith’. This refers to in particular the way that BAC men are detained, which is often via the criminal justice system. The literature re-iterated that BAC males detained under mental health legislation are usually younger, from socially deprived areas, unemployed, and with lower

educational attainment. They also have lower levels of trust for healthcare and criminal justice. The silences discussed in this theme were about the (mis)understanding of the complexities within the intersectional identities of the BAC males detained under mental health legislation. Person-centred care must seek to understand and care for the whole person beyond their race, allowing for a nuanced understanding of gender, sexuality, and class. In an example provided by an expert by experience, they explain that not only are they Black, but they are also a product of where they have been brought up, their sexuality, and much more. Those identities matter and will not only shape one's own behaviour and perspective, but will also most likely shape the behaviour and perspective of those who provide mental health care, similar to the ways Blackness can be perceived in services.

Culture, spirituality and religion

There was limited information from the literature within this theme, but it was a topic that was important to the people with lived experience from all of the workshops we ran. The needs of patients who expressed forms of spirituality were medicalised and the 'features' of their beliefs were documented in their clinical notes. These notes omitted to record any other cultural information about them. Services that do not utilise spiritual or religious practice as part of the healing process could be making issues worse for the patient and enhance their traumatic experience of being detained. There is a consensus in the literature that health professionals working in psychiatric services need cultural competence training to support patients and other staff members, ultimately improving services for everyone. The silences discussed within this theme were very personal and they felt that all spirituality outside of Western cultural norms (i.e. Christianity) were not understood or explored. This contributes to the silencing of anyone outside of this 'norm'. It also creates mistrust between the clinicians and the patients, whereas embracing spirituality could be healing for most people.

Power, language and communication

Coercive and oppressive communication styles, laden with inaccessible medical jargon, contribute to patient disempowerment and fear of health services. BAC patients in the literature were reported as feeling fatigue in fighting racism, especially within oppressive systems such as education, criminal justice and healthcare. Racial disparities in detention and diagnosis are clear within the literature, and it is BAC males who are more likely to be diagnosed with a schizo-affective disorder, spend longer in compulsory detention, and are more frequently readmitted to in-patient facilities. As a result, there is a disconnect between BAC males and their trust in the health system. Experts by experience reported that there was an obvious power play by medical staff which resulted in patient confusion, often silencing them as they felt inferior and conflicted. They felt that if they did speak up, or spoke up on behalf of a loved one, they would be treated badly, or would be ignored.

Experiences of BAC men who are detained under mental health legislation have not changed in meaningful ways for at least the past twenty years. The systematic literature review shows how research papers report the same issues repeatedly: BAC men are younger, usually diagnosed with psychosis, have longer hospital stays, are more frequently readmitted, are unhappy with their treatment, and are more often detained through the criminal justice system than any other demographic. Their voices are missing from the literature until now, but the statistics show that the over-representation of BAC men in mental health detention comes at a human and financial cost and demands attention. Presenting

the findings from the existing literature alongside the voices of those with lived experience is a way of changing the narrative and exposing the silences.

3.1.7. Recommendations from the literature review:

- **Patient involvement and clear communication:** Patients should be actively participating in their treatment decisions where appropriate. This should be supported by clear communication, and consideration of their culture and spiritual background, ensuring their voice is central to discussions about their healthcare.
- **Reducing disparities through anti-discriminatory policies and practice:** The implementation and enforcement of antidiscrimination policies would help to ensure the equitable treatment of BAC men. This would help to address biases in referrals and admissions, creating transparency, regular review, and disruption to systemic racism.
- **The promotion of cultural competence:** Bridging the gap between medical and spiritual healing requires collaboration and exploration of diverse therapeutic approaches. Ongoing cultural competency training in collaboration with community and spiritual leaders is important to create sustainable and informed change. Training should also consider staff cultural backgrounds and how perceptions by patients and other members of staff can be positively impacted.
- **Community campaigns, collaboration and support for carers:** Community campaigns, collaboration, and support for carers can help reduce the stigma of mental health and improve access to early interventions, GPs, and support networks, potentially lowering rates of compulsory detention among BAC men.
- **Monitoring and auditing**: Being aware of the issues around the disparities for BAC men in mental health services should be subject to accountability. This means that monitoring and auditing should take place on a continual basis to ensure that psychiatric and mental health services are complying with changes to policy and practice, and are able to respond to any other issues that may occur in a timely manner.
- **Improving future research through embracing coproduction**: Future research should be collaboratively developed with experts by experience to address disparities and create meaningful change in mental health detention policies and practices.

3.2. The EBCD study

The EBCD study was approved by HRA and the Health and Care Research Wales (IRAS ID 310503); participation was subject to consent.

3.2.1. Specific objectives included:

To explore the BAC men's and significant others' experiences of detention and mental health services;

- To explore the views and experiences of professionals involved in the detention process, including approved mental health professionals (AMHPs), psychologist and psychiatrists and police officers;
- To bring together professionals involved in the detention process to validate emerging findings and identify areas for change/improvement; and
- To bring everybody together, i.e., a wide range of stakeholders involved in mental health services and the detention process, including those who participated in the

previous stages of the research) to discuss emerging findings, identify further silences and key areas/actions to facilitate change.

3.2.2. Methods used to achieve these objectives:

- 13 x one to one in depth qualitative interviews with professionals were conducted between 25th January and 17th November 2023, including Psychiatrists, Approved Mental Health Practitioners (AMHPs), Police officers, and Clinical Psychologists. These explored why they think BAC men are detained far more than their White counterparts and what they suggest needs to change and how.
- 1 x focus group (FG) with 10 BAC men, family members and BAC community pillars was conducted on 29th November 2023. A focus group with attendees of one of our community events (see below poetry and art workshop) was held to reflect on the masks and poetry created at the workshop gain a deeper understanding of the community's experiences of mental health services. Fears around the complaints process in services, the negative effects of medication and how that disproportionately affects BAC people were discussed, while examples of good practice were identified.
- 1 x feedback focus group with 5 professionals and 5 researchers conducted on 19th December 2023. This included professionals that participated in the one to one interviews to discuss and validate emerging themes and identify any missing information.
- 1 x co-design event undertaken on 28th February 2024 with 46 stakeholders, including BAC men, family members, pillars of the community who deliver informal mental health support, third sector/lack mental health charities, police officers, social workers, AMHPs, clinical psychologists, mental health nurses and psychiatrists, advocate organisations.

Three additional workshops/events were organised to both contextualise views and experiences of the mental health detention process (from a professional and individual with lived experience perspective) and to empower and engage with communities of BAC men, significant others and key community pillars and organisations providing both formal and informal mental health support:

- 1 x community mental health celebration event on 18th May 2023;
- 1 x art-based workshop on 17th October 2023 attended by 30 BAC men and family members. In this last event, participants engaged in creative methods to express their experiences and feelings about mental health, including song and poetry writing and mask painting; and
- 1 x workshop on 16th August 2023 to explore and discuss the police's views and experience of mental health detention and inequalities. Attended by 12 police officers with a wide range of roles, the workshop brought up issues regarding challenges with sections 135 and 136, their relationship with BAC communities and people with mental illnesses. Key challenges they reported was a lack of understanding, training and experience, in terms of both BAC communities and mental health calls, and a breakdown in communication between police and mental health professionals.

3.2.3. EBCD Methodological Challenges

One of the key challenges experienced within this project was the recruitment of BAC men within EBCD. This was due to two systemic issue (1) the target population and (2) generational and systemic mistrust BAC communities have towards the police, mental health services and educational institutions due to historic experiences of racism and discrimination.

Issue one: The SF requires participant's to be individuals or groups of people who are not already engaging with services, universities or community initiatives, for various reasons (often to do with stigma, socio-economic inequalities, mental health or other disabilities). The SF specifically targets silenced groups whose stories are not yet told. We chose former patients with detention experience who had been released back into the community as they are not obliged to take part in research for the benefits of their care. In addition, other projects funded by the same call were already investigating the experiences of inpatients therefore, this project wanted to contribute to the body of work with a different voice.

Issue two: This bid was submitted in January 2020, prior to the Black Lives Matter movement in May 2020 which acted as a catalyst for racial disparity research. Amongst this flurry a number of significant racial disparity reports, minority race research engagement tool kits and frameworks were published which had a direct impact upon ImproveAct's original research proposal; specifically, the EBCD one-to-one interviews with BAC men and their self-identified significant others.

ImproveAct is predominantly a Manchester based research project however the Policy Connect work package feeds our findings directly into the Government's agenda to reform the Mental Health Act. The Commission on Race and Ethnic Disparities Report (2021) showed that BAC communities in Manchester, despite having a high prevalence in mental health conditions, are the population with the least engagement in mental health research. The report details the generational and systemic mistrust BAC communities have towards the police, mental health services and educational institutions due to historic experiences of racism and discrimination. These are the three institutions that directly straddle ImproveAct and reflect our recruitment challenges with BAC men.

Whilst BAC men did agree to share their stories/accounts of detention as soon as the PIS and consent packs needed signing the men withdrew. This was not a reflection of the team, but the formal research procedures and process the men had distrust in. The systemic issues of historic experiences of racism and discrimination needed in-depth exploration and focus, causing the team to pause, re-examine and find creative solutions to engagement challenges, so the trust can be rebuilt before BAC men can feel safe to share their experiences.

After in-depth consultation with our PPI group and Co-applicants with lived experience we evolved our research proposal to focus on wider community engagement first, and the idiographic accounts of BAC men second to truly re-build the history of distrust.

The Commission on Race and Ethnic Disparities Report (2021) highlighted the need to overcome engagement challenges through four principals of trust building, fairness, agency and authentic inclusivity. With help from our PPI group and we utilised the INCLUDE Ethnicity Framework (Treweek et al, 2021), the RDS Equality, Diversity and Inclusion Toolkit

(2020) to devise a grass roots community engagement strategy. The aim was to find an appropriate replacement method for the one-to-one interviews.

Art based mental health events held in, by and for the community were conducted to find pillars in the BAC community. After these were successful, art-based focus groups for BAC men and their significant others was the preferred data method chosen by the community as they offered an authentic, meaningful data collection approach to re-build trust.

Focus groups provided safety in numbers for men to openly speak together about their experiences of racism, detention, mental health crisis, and the way in which historic research has been done on them not with and by them. There was safety in the art-based techniques as the traumatic events experienced could be depersonalised and projected onto an item (the masks or a poem) rather than the men feeling overtly vulnerable sharing their individual accounts. The process of making and creating the poem or designing the mask helped the men/significant others process their emotions safely rather than being potentially re-triggered by recalling potentially supressed traumatic experiences.

In addition, embedding ourselves in the BAC community was of highest priority. This meant using community venues/business/spaces known to and ran by BAC community pillars. The food served was from African Caribbean origins. Music is embedded in the BAC community in a way that is not in the White community. *"…We have been pressed and pushed down for years. It is through the arts and music and creativity that we can unsilenced this oppression" (BAC participant)* hence a local Caribbean band were invited to play at every ImproveAct event facilitating a safe, empowering space. Amending our original protocol to adopt this approach created lasting engagement from local BAC communities in mental health research and built a legacy that spans beyond the ImproveAct project.

To be truly authentic the team then re-visited all work packages to re-examine how to include the BAC voice in, and through every work package in a bottom-up approach. The role of people with lived experience in our project evolved from being a PPI group to performing as co-applicants contributing to the analysis, decision making, co-authoring, and presenting at all our events and conferences. This approach started to repair the distrust and rebuild the relationship between Manchester's BAC community, academia, the police, and healthcare services which will boost engagement and recruitment for future research projects:

> *"I have never been a space where I felt safe enough to share my story. Never. You [the ImproveAct team] have created this space [co-design event] and for that I thank-you" (BAC participant)*

3.2.4. Analysis of EBCD findings

Qualitative interviews and FGs were anonymised and thematically analysed between September and December 2023 using Braun and Clarke's 6 phases of reflective thematic analysis (2021). This was done by two members of the EBCD team and validated by two other members of the research team and people with lived experience part of the PPI group. The challenge the team now faced was how to bring the findings from the interviews, FGs and community workshops together that still tell the accounts of detention but acknowledge the lack of detail that one-to-one interviews provide. Methodological triangulation was that solution.

3.2.5. Methodological triangulation

When all data was collection was completed, emerging findings from the systematic review and the EBCD study were brought together to develop a comprehensive understanding of the detention experience using methodological triangulation (Noble and Heale, 2019). Methodological triangulation is one of four triangulation methodologies used to provide confirmation/validity of findings, more comprehensive data sets, increased validity, and an enhanced understanding of the studied phenomenon (Bekhet and Zauszniewski 2012).

The challenges the team faced when recruiting BAC men meant changing tack from one-to-one interviews to FGs. FG data is not a typical collection method used in EBCD. Hence, methodological triangulation is a method successfully used to strengthen the overall outcomes of the study and decrease the weaknesses of an individual component of a study (Bekhet et al, 2012 ; Denzin 1978, Sharif and Armitage 2004).

With findings deriving from multimethod approaches the critique could be that there is incompatibility between the analysis and/or theoretical paradigms. Every care was taken to overcome this during the research data collection phases. All data collection was independently complete (Morse 1991, Casey and Murphy 2009). The research team ensured each method was rigorous and complete using Casey and Murphy's (2009) four evaluative criteria of: 'truth value', 'applicability', 'consistency' and 'neutrality' for rigour.

We achieved 'truth' through participant quotations that objectively captured individuals' experiences (Guba and Lincoln 1989). 'Neutrality' and 'applicability' was achieved by reaching data saturation (Casey et al, 2009), with new data continuing to be collected without additional themes arising (Guba et al. 1989). 'Consistency' was achieved because our ideas were presented and validated to multiple stakeholders at multiple events detailed below (Bekhet et al 2009).

In addition, one key limitation of methodological triangulation includes using varying/unclear research question(s) across multiple data sets (Casey et al., 2009). it is vital to have a focused research question(s) that is concise to overcome this limitation (Mitchell 1986, Dootson 1995, Begley 1996, Casey et al., 2009). In all our qualitative data sets the primary question was: '*what are the experiences of BAC men who have been detained under mental health legislation*?' and '*how can those experiences be improved*'? The simplicity, focus and clarity of this overcame most methodological triangulation challenges.

There are two types of methodological triangulation: 'across method' and 'within method'. Within-method was applied to all ImproveAct data as it allows multiple data-collection methods (from the same tradition e.g. all qualitative data) to be analysed across the project (Casey and Murphy, 2009). In this case that included analysing across FG data, the professionals' interviews, the Silences Review, and the three community workshops to come up with one set of overarching ImproveAct project findings. All datasets being from the same tradition (e.g. qualitative) meant we overcome any limitations around opposing multimethod theoretical lenses.

Methodological triangulation can be 'sequential' or 'simultaneously used' (Creswell and Plano Clark, 2006). The research team chose 'simultaneous triangulation' as this is best used when the multiple qualitative data set findings speak to or complement one another. Despite using multiple methods to collect the data, the findings from the multiple perspective of people involved in the detention process (including AMPHS, social workers, police,

psychologists, psychiatrists, mental health nurses, BAC mental health advocates and charities, BAC men with detention experience, pillars of the BAC community and carers of people with detention experience, and mental health trusts) the multiple perspectives did all complimented one another validating further the use and choice of methodological triangulation.

Despite the clear benefits of methodological triangulation, the operationalisation process itself is limited by the lack of research explaining how to apply this (Farmer et al 2008). Meijer, et al. (2002) describe three triangulation approaches that the team considered: (1) the intuitive approach (mostly commonly used) where researchers intuitively relate/compare/contrast findings from different data sets to each other; (2) procedural approach, where researchers endeavour to document each triangulation step to ensure transparency and replicability; and (3) the intersubjective approach where researchers work iteratively to reach an agreement about the multiple steps in their triangulation process.

The research team applied all three approaches to the ImproveAct findings. Firstly, through the ‘Intuitive approach’. Three experienced researchers collated all data sets (the review, the focus groups, the professional’s interviews, and the community workshop discussions) and compared/related findings to each other using an online whiteboard software called Padlet (see Appendix 4).

Ten themes emerged on the Padlet and were coded with the abbreviations ‘PFS’ and ‘LE’ as keys to the origins of which data set that theme came from. ‘PFS’ were the voices of professionals and ‘LE’ were people with lived experience including BAC men, trusted community pillars identified by the BAC men and their significant others/carers.

Using the ‘intersubjective approach’ the ten themes were discussed at length with the wider research team and the PPI group, then an agreement was reached to categorise these into three ordinate themes with ten subordinate themes. At this stage the themes were still unnamed.

These unnamed themes were presented at the EBCD co-design event in February 2024. In attendance were the research team, AMPHS, social workers, police, psychologists, psychiatrists, mental health nurses, BAC mental health advocates and charities, BAC men with detention experience, pillars of the BAC community and carers of people with detention experience.

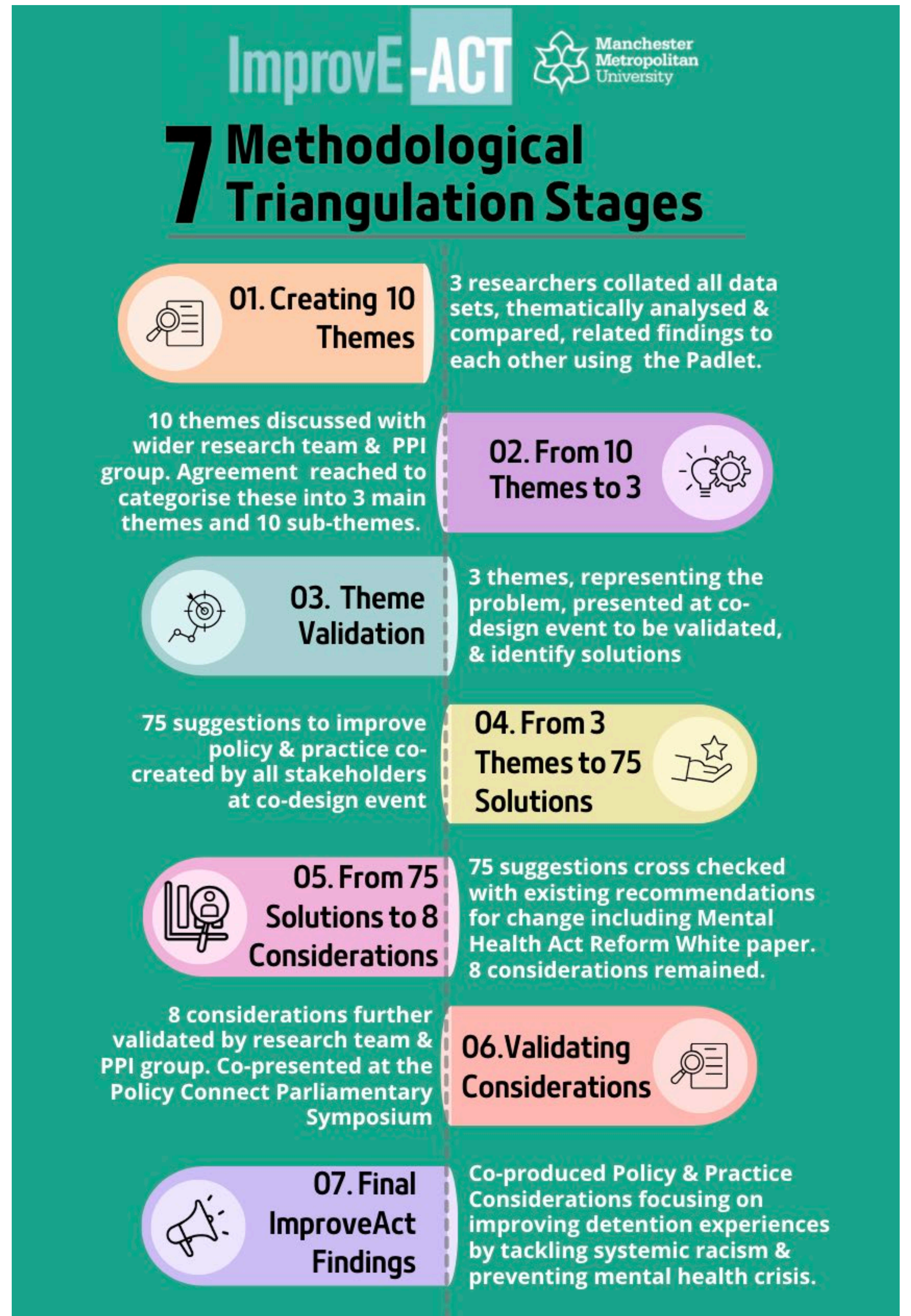
The purpose of the event was to firstly validate, name and discuss the themes. Discussions identified that the themes represent the problem – the inhumane experience of detention as experienced by BAC men and their significant others. We then moved beyond that to discuss the solution (how to improve these experiences) and begin turning those suggestions into considerations for policy, practice, and future research.

To do this, participants co-created seventy-five suggestions for policy and practice consideration. This was done through minutes taken during group discussions, cartoon illustrated minutes (see figures 3-5) post-it-note suggestions, and self-completed event feedback forms. After the event, two experienced researchers analysed the 75 suggestions by prioritising them in line with aims/objectives/scope of project (e.g. improving BAC men’s experience), removing any/all repetition, comparing/contrasting suggestions with Improve Silences Review findings, then again against current findings of Mental Health Act Reform White paper. After this process eight considerations remained.

Triangulation continued by validating the eight considerations again with the wider ImproveAct research group and the PPI group before being co-presented by the research team and people with lived experience at the Policy Connect Parliamentary Symposium in Westminster in March 2024 and discussed in detail. These '*ImproveAct Policy and Practise Considerations'* (see section 4.2) are new initiatives co-produced and created from the ImproveAct findings. These focus on improving the experience of BAC men being detained, tackling systemic racism, and preventing mental health crisis.

This summary and the diagram below (***Fig 2***) illustrating this summary, is the research team's endeavour at the methodological triangulation 'procedural approach', where researchers attempt to document each triangulation step for transparency and replicability. These stages are how the overall ImproveAct results (see section 5) were created.

Figure 2. ImproveAct's Seven Stages of Methodological Triangulation



4. Overall results: ImproveAct key themes

Three key themes and ten sub-themes were identified.

Theme 1. Identities Beyond the Mask

This theme seeks to understand the identity of the BAC men through the lens of spirituality, stigma, and racism.

Figure 3 - ImproveAct Theme One: Identities Beyond the Mask

Sub-theme 1: Identity

Health and social care practises should adopt person-centred approaches that acknowledge the traumatic weight of racism in shaping individual identities. Reforms must address the tendency to treat BAC men monolithically in both law enforcement and mental health services, emphasising the importance of being treated as individuals rather than inappropriate Black mask stereotypes. Care that only acknowledges one aspect of an individual (e.g. race) fails to provide true person-centred care. Skin tone, gender, class, region all plays a part in how people exist in the world and how people are treated. This

means both the individual and the community are important. Community-based support is a vital part of mental health services and has been referenced many times when hearing people with lived experience share examples of good practice. Community initiatives that are led for and by people with lived experience need amplifying and long-term funding.

Sub-theme 2: Spirituality

Religion and spirituality should be integrated into mental health support for BAC communities. Religion and spirituality are an important part of many BAC men's identities and is where they turn to for support or peace during difficulties and crisis: *"Meaningful change will only happen if we work collaboratively with the Black community including faith leaders" (BAC participant).*

Black communities hold the highest valuation for religion in their individual lives (Pederson, et al. 2023). They report finding support and solace in their religious and spiritual practices and communities during times of need (Taylor, et al. 2021). Despite religion and spirituality serving as a protective and positive functions for BAC men, this can also create tensions for patients within mental health systems that emphasize a biopsychosocial framework (Peteet, et al. 2022). The inclusion of religious or spiritual problems in the V codes of DSM IV-TR consider spiritual and religious aspects of major diagnostic categories including schizophrenia and other psychotic disorders, depression, substance use disorders, anxiety, PTSD, and personality disorders amongst others (Chandler, et al, 2012; Prusak 2016). Therefore, BAC men are often hesitant to express religious beliefs/practices for fear these beliefs will be pathologized, leaving out key dimensions of spiritual well-being and practices in assessment and formation. This demonstrates *"…the need for research and training of spirituality in Mental Health services so that spiritual beliefs/practices are honoured and embedded as support and not misdiagnosed as psychotic symptoms" (BAC participant)*.

Reforms should allow for the integration of religious and spiritual practices into mental health support systems. This involves creating culturally sensitive approaches that validate and incorporate diverse belief systems.

Sub-theme 3: Stigma

Combatting racism in healthcare: promoting equity and cultural competence. In healthcare settings, discomfort with discussing race can impede effective communication and rapport-building with patients. To address racism effectively, the setting should implement reporting and logging mechanisms for incidents of racism and integrate anti-racism training into professional development that includes the recognition of both conscious and unconscious biases:

> *"Staff feel oppressed and implicitly complicit because the systems they work within are intrinsically racist and the Mental Health Act dominating it is racist. They workday in day out trying to do their best in a system that jars against their values and end up burning out or leaving" (Professional participant).*

By acknowledging the interconnectedness of racism, injustice, and mental health diagnosis, the mental healthcare systems can foster a more equitable and culturally competent healthcare environment benefiting both staff and service users.

Sub-theme 4: Racism

Addressing stigma in mental health services through acknowledgment of racial trauma, cultural sensitivity and promoting individualised mental health support. Racism and the harm

faced by people in mental health services are linked as BAC men's experiences of racism is sometimes treated as part of their mental illness. Racism and anti-Blackness faced in the past is intrinsically linked to fear or services and being detained. A traumatic fear response, caused by historic trauma, can present as a fight or flight reaction that is misinterpreted as aggression: *"…a need for teaching/training about aggression not being aggression but as a justified result of trauma and fear of death" (BAC participant).*

The stigma surrounding BAC men's mental health is often associated with perceptions of aggression and stereotypes of 'big Black men'. To combat this stigma, it is crucial to examine how Whiteness influences the provision of mental health services, with a focus on ensuring services are culturally sensitive and person led. For example, this would ensure that practitioners recognise when an individual's behaviour is a trauma response rooted in their racial discrimination.

Theme 2. Re-humanising Detention

This theme addresses the systemic power imbalances, misconceptions, and injustices currently operating within the whole detention process.

Figure 4 - ImproveAct Theme Two: Re-Humanising Detention

Sub-theme 5: Power imbalances

Empowering individuals through a transparent and humanised detention processes. The current detention process lacks transparency and humanisation, leaving individuals feeling powerless and disconnected from their care. Policies must prioritise humanising communication during and after detention, ensuring individuals understand what is happening to them and why. This involves demystifying jargon and making pathways to care more visible and accessible:

> *"Information needs to be provided to patient and their loved ones about what is happening to them and their rights. That information needs to be in multiple accessible forms including QR codes to a film. Not just in written formats" (Carer participant).*

Additionally, it is essential to address the arbitrary nature of the detention process, which often disregards the individual's needs and rights. Families worry about making complaints

in case it worsens the person's treatment. To empower individuals, policies should encourage open communication without fear of repercussions, allowing families and carers to voice concerns openly:

> *"Mental Health professionals need to take time to reflect with patients, carers and staff who have been involved in the Mental Health Act if they have been heard. Do not judge the voice of carers. Let them speak and listen. Involve them in care" (Professional participant).*

Sub-theme six: Misconceptions

Dispelling misconceptions surrounding aggression and risk in detention. Policymakers must prioritise understanding aggression and risk from both the perspectives of professionals and individuals with lived experiences:

> *"…there's a perception of Black men generally in society but also in mental health services as well, that they are generally more aggressive, they're described as aggressive more than not, and I think a willingness to understand where that behaviour comes from and what's driving that behaviour is clouded by that view" (Professional participant).*

This entails exploring the nuances of risk perception and questioning who is being protected from what risks during detention and creating training to explain these nuances:

> *"We need a resource to train all Mental Health practitioners about what we hear today [ImproveAct themes] – Black men's experiences of detention, the police, the inequalities faced and the harm as a result of this" (Professional participant).*

Sub-theme seven: Injustices

It is crucial to recognise that the act of detention can itself perpetuate violence and aggression, particularly for BAC men who may experience it as a form of victimisation:

> *"When they're unwell and they don't think they need admission, but the police turn up and they think, last time, this is what the police did to me. I need to run, I need to get out of here, it's going to increase their fight or flight" (Professional participant).*

Consequently, a person who exhibits aggression during detention may be doing so to protect themselves from violence they are experiencing, or that fear they may suffer, in detention:

> *"When we went up to do the assessment, he let me and the AMHP in, but he didn't want the police to come in because he said, "I've had bad experiences with the police, I don't want the police in there" (Professional participant).*

These perpetuated feelings of injustice may lead to BAC men rejecting mental health services and relying on support within their own community. BAC men often struggle to rediscover their voice after detention. Poor experiences of treatment lead to BAC men feeling that silence is safer:

> *"You just think, if that was a big White man and they had said, we need back up, there's a big White man here, would 15 coppers show up? I don't think so. I think it's just institutional racism, that term 'big black man' (Professional participant).*

Theme 3. Radical Reform
This theme works towards a more equitable and inclusive Mental Health Act for all by unpacking mental health care, treatment, and medication.

Figure 5 - ImproveAct Theme Three: Radical Reform

Sub-theme eight: Care
Transforming mental health care for equitable and culturally sensitive support. The UK's mental health care system should be characterised by needs-led and trauma-informed approaches:

> *"A more person-centred admission plan...I think maybe more support around the person having their voice heard...Basically, it being more person centred" (Professional participant).*

This means that individuals have the opportunity for joint decision-making with practitioners instead of being forced into pre-existing care packages:

> *"Maybe afterwards, the care coordinator or someone to speak with the person to get their feedback of how the detention process was for them...it's the person in the middle of it and getting their feedback is probably the most important thing in how we change legislation and make a positive change" (Professional participant).*

Mental health care pathways should encompass community-based care, from pre-detention through to post-discharge, with a focus on addressing trauma experiences during detention. Involving families in care decisions and explaining the Mental Health Act are crucial steps in fostering understanding and support. Additionally, diversifying the healthcare workforce and incorporating transcultural psychiatry principles into assessments and interventions are essential for providing culturally adapted care for BAC men:

> *"The messages to those people making decisions around services is, think very carefully about when you are involved in communities, in decisions, actually whose voices are not being represented? And how are you going about trying to capture some of those voices" (Professional participant).*

Sub-theme nine: Treatment

Professionals lack full understanding of spirituality/cultural beliefs when assessing for psychosis and schizophrenia. This can lead to racist practices from professionals around diagnosis and medication management (e.g., diagnosis is applied via a Eurocentric diagnostic manual). BAC men are sometimes mistrustful of anti-psychotic medication and the medical claims given about how it can provide relief from hearing voices. Professionals agree asking for *"…culturally appropriate education around mental health difficulties and how those can manifest" (BAC participant).*

Treatment reforms require practitioners to put the person before the practice. One participant from the co-design event asked, *"can we have these themes framed and taught about in light of MH assessment so practitioners can have them as a culturally appropriate checklist against implicit racist decision making" (Professional participant).* The radical-ness of this means instead of operating on the Mental Health Act's principle of what is least restrictive approach, practitioners should operate on what is the most supportive approach for this person. This would result in a transcultural, recovery focused assessment, care and support detention process.

Sub-theme ten: Medication

Enhancing medication practices for equitable mental health treatment. Health system reforms should address the systemic issues surrounding medication in mental health care, includingmedication side effects, and concerns about control:

> *"There is a legitimate suspicion of how medications are developed, what pharmaceutical companies' real aims are and about the safety of medications… medications are generally developed and tested on White populations… If you thought about the long-term, from the early stage and either got the dose right or minimised side effects to make it more tolerable…then would almost certainly reduce the chance of …readmission" (Professional participant).*

Current diagnostic manuals and drug testing primarily cater to White populations, leading to mistrust among, and ineffective treatment of, BAC communities. By adopting more inclusive drug testing protocols, minimising medication side effects, and promoting culturally competent assessments, the health system can ensure that medication practices in mental health care are more equitable and effective for all individuals.

Contextualisation of Results:
It is important to note that this report only provides a snapshot birds-eye overview of the ImproveAct findings. There are (detailed in the dissemination section) multiple forthcoming ImproveAct papers with further evidence focusing on further interpretation and contextualisation of these results, in line with current policy and practice. Significantly, the upcoming overall findings paper (Craig, E., et al. (n.d.) *'ImproveAct: Considerations to Improve the Detention Experience By and From the Black Community')* will delve deeper into the findings presented here. This will provide a richer, more detailed insight into the themes including how they interact, contradict, contrast, and compare with the current evidence, as well as contextualising them within existing theoretical frameworks.

5. ImproveAct Key Policy and Practice Considerations

5.1. Develop a community-led multi-agency independent advisory group to address detention-led inequalities for BAC people and racism

> *"We need an opportunity to join as a collective voice to keep this issue in the spotlight" (*Professional participant*).*
>
> *"Let's set up an independent advisory group with Greater Manchester Police and two mental health trusts and Greater Manchester Integrated Care Partnership and Greater Manchester Combined Authority executives once every three months to challenge mental health" (*Professional participant.*)*

The ImproveAct community-led independent advisory group should include faith leaders and key community pillars, people with lived experience and their significant others, social workers/AMHPS, advocates, the police, NHS mental health trusts (including a wide range of health professionals involved in the detention process, e.g., ambulance staff, nurses, psychiatrists and psychologists), representatives from the local authority and integrated partnerships.

Each member of the advisory group will lead on the actions relevant to their area/interest/expertise and nominate ImproveAct champions to take on implementing the work and facilitating change. The group would meet on a quarterly basis with an annual public meeting to allow for feedback-feedforward into and from the community; challenge any outstanding issues and action them, to provide for accountability and follow up. The group will also identify a safe space in the community for both multi-agency work, as well as at crisis point, church/community hub based rather than police/hospital/statutory organisation based.

There is a need to investigate and learn from deaths of BAC people detained under the Mental Health Act. The disproportionate number of deaths of people from Black, Asian and Minority Ethnic Groups following restraint is particularly prevalent amongst BAC males, with deaths in custody of people from racialised groups being almost two times greater than other deaths in custody. People like Sean Rigg, Olaseni Lewis and Kevin Clarke are real life examples, whose death impacts not only upon their family and friends but also has a

broader ripple effect across racialised communities and society (INQUEST: Black, Asian and minoritised Ethnicities: Deaths in police custody).

In July 2021, the United Nations High Commissioner on Human Rights, Michelle Bachelet, published a report that called on nation states to 'end impunity' for human rights violations against BAC people by police officers and reverse the 'cultures of denial' to address systemic racism. There is a clear impetus to address human rights violations internationally and the ImproveAct advisory group could follow the rationale and set up Domestic Homicide Reviews (e.g., establish what lessons can be learned from the circumstances of the death and the way in which local professionals and organisations worked individually and together) to address racism, dipropionate detention and BAC mental health inequalities. As these specific reviews are not currently commissioned, the group could co-design the need, format, process, etc of these reviews.

The ImproveAct advisory group would meet on a quarterly basis with an annual public meeting to allow for feedback-feedforward into and from the community; challenge any outstanding issues and action them, to provide for accountability and follow up. This would help rebuilt generational systemic mistrust and begin addressing the power imbalance between the community and the mental health institution.

5.2. Develop cultural appropriate/humility training

> *"I explained that training needed to be delivered to patients, carers and professionals collectively. The representative responded with the counter view that professionals should have separate training specific to them. I don't agree, as it appears to be a power dynamic, coming from a place of privilege. What I'm curious about is whether the trainer's response was conscious or unconscious. I was left feeling this was a prime example of my lived experience of power and control..." (Carer Participant)*
>
> *"I think we need to be educating our (psychiatric) staff about their experiences (of detention)" (Professional participant).*
>
> *"Culturally appropriate education around mental health difficulties and how those can manifest" (Carer Participant).*
>
> *"Training needs to include short films with the voices/experiences of Black men" (Professional participant).*
>
> *"Push the culturally aware agenda in MH trusts that includes films of the Black men's experiences to fill the gaps or silences. Defining what racism is within that, and having a framework that can and will challenge and hold people to account when racism is evident." (BAC participant).*

The culturally appropriate training must be underpinned by cultural humility; this is not just a learning exercise of another person's culture but understanding that our western dominated mental health system/beliefs are a source of this imbalance of power, e.g., "Your culture is not more right/more important than mine".

To do this we should develop films with BAC people and their significant others to capture their insight and experiences about mental health, detention, trauma and triggers as a result of the process. This will also help identify examples of racist language (e.g., how to talk about race), attitudes and practice. This will be co-produced, within the safe space provided

by the ImproveAct advisory group and will be available to all organisations solely for training purposes.

These films will be incorporated within existing (or new) training delivered to a wide range of organisations, including the police, NHS trusts, Royal College of Nursing, Royal College of Psychiatry, British Psychological Society and British Association of Social Work guidelines/standards, as well as to university students in nursing, social work, psychology, policing. The films and the overarching ImproveAct themes could be used by practitioners involved in the mental health detention process as a culturally appropriate checklist against implicit racist decision making.

5.3. Develop 'Go to Mental Health Hubs' in the community

> *"As men we suffer quietly […] but we have nowhere to run to and nobody to share with and we have also issues like isolation. We need a safe space sanctuary to bring us together…the Black men to do some work around us" (BAC Participant.)*
>
> *"Create a directory of community businesses alongside statutory services that could support as alternatives to admission" (Professional Participant).*
>
> *"Black and ethnic minority men and we'll struggle and probably do struggle to access mental health services in the community because they're probably viewing it as a you know stigma" (BAC Participant).*
>
> *"I think some joint working…with Church leaders" (Professional Participant).*
>
> *"It's giving family members time to think things over...kind of reach a decision collectively" (Professional Participant).*
>
> *"Community based support is key – best space to open up, un-silence silences, re-build trust in oneself, the community and support services..." (BAC Participant).*

The hubs would encourage a shift from a medicalised model of support to a community based, safe space; they will encourage conversations in the community about mental health before it gets to crisis; they could be the first point of call/referral to counselling, buddy, mentorship support. Piloting these would be the next step for research including exploring the best place to put these in situ.

The hub could be a community church, a café, community centre. The option for having the community church as a safe space for detention (while awaiting assessment) should be explored. Church is where BAC people go when they are struggling.

The 'Go to Mental Health Hub' will host the annual meetings from ImproveAct's advisory group. They will also be able to provide training on how to deal with Mental Health crisis and safeguarding issues. The hubs could be a place where 'living libraries' are accessed – this will be films about BAC people's stories of recovery from mental health crisis, celebrating life and achievements.

Patients and their chosen support/loved ones need to be informed about the detention process and their rights in multiple accessible forms, including QR codes to a short film (not just in written format). The 'Go to hubs' in the community would provide 24/7 quick and confidential access to this information and signposting to available support and further

information on what to do next. This will also include crucial information about assessment, hospitalisation, tranquilisation, medication and side effects.

5.4. Enable advocacy, rights and complaints

> *"There's a cage on the mouth…they caged up our mouths, we've been deprived of knowledge for so many years and were unable to speak our hearts and what's in our minds" (BAC Participant).*
>
> *"A system to challenge any bad conduct to treatment" (Professional Participant).*
>
> *"How can we 'fix' people in a broken system, one which suffers from institutional racism? We need to consider conscious and unconscious bias in professionals, challenging racism in practice. For practice to be truly progressive and based on human rights, this includes reporting and logging incidents of racism." (BAC Participant).*
>
> *"I am also a carer. I have supported my son through local, medium, high and low secure forensic services for over fourteen years. It's been a journey. There have…been some examples of good practice. However, the hardest part has been challenging practices inequalities, disparities, gaslighting and coercion to name a few within services." (Carer Participant.)*

There is a need for culturally appropriate advocacy in Mental Health trust's hat the patients can challenge disagreements in assessments or support delivered, as well as decision making regarding medication. We recommend creating culturally appropriate advocacy in Mental Health Trusts that the patients can challenge disagreements in assessments or support delivered, as well as decision making regarding medication.

When a complaint is being made by a patient or carer regarding perceived injustice and racism in decision making about detention, this should be followed through, including penalising where appropriate the staff responsible and informing the patient about the outcome. This will help eradicate a culture of racism and rebuild the trust between the BAC community and the mental health institution.

5.5. Rebuild trust between the police and the BAC community

> *"…the biggest fear for Black men must be the thought of being restrained by the police." (Professional Participant).*
>
> *"I think there's a perception of Black men generally in society but also in mental health services as well, that they are generally more aggressive, they're described as aggressive more than not, and I think a willingness to understand where that behaviour comes from and what's driving that behaviour is clouded by that view" (Professional Participant).*
>
> *"There's a huge disparity that needs linked up between police and MH services. More Mental Health professionals' input/communication is needed to police when requesting welfare checks/return to ward to avoid unnecessary force and harm" (Professional Participant).*

Police an MH Training is needed to identify illness and usual presentations of MH" (Professional Participant).

Police training needs to include the co-developed ImproveAct short films with the voices/experiences of BAC men and their significant others. This includes creating police training to help officers better recognise key signs of PTSD to prevent unnecessary re-traumatisation. Also training to understand that people's challenging behaviour might be a re-triggering of a previous negative experience of police detention or fear of death; learn how to de-escalate and avoid use of restrictive practices above and beyond the 'usual' detention procedures.

Included in police training should be a module to help officers better recognise key signs of PTSD to prevent unnecessary re-traumatisation. Also training to understand that people's challenging behaviour might be a re-triggering of a previous negative experience of police detention or fear of death; learn how to de-escalate and avoid use of restrictive practices above and beyond the 'usual' detention procedures.

The Community Hubs could be used as a safe space to regularly open conversations, understand each other's roles, experiences, triggers and best way to avoid them.

5.6. Shared decision making and person-centred care

"We can actually open our mouths and express ourselves in art, in music and in food…" (BAC Participant).

"Each case is different and seeing each person as an individual is important. We are constantly evolving. It's essential to ask someone in crisis about their lived experiences. Having a mental health issue is a journey in a difficult and racist world. If external factors make the person sick, then racism can seem like an illness and have lasting effects. The culture around mental health must change for us all to be well" (Carer Participant).

"They were describing the framework solely from their professional perspective and trying to tell us, the patient, carer, how we should use it. That's not equity, co-production, or partnership working. My request is simple. It's essential we work it out together, sharing learning and understanding" (Carer Participant).

"Trying to find what brings self-love out of you and for me that's creativity. Telling our story. That's how I heal" (BAC Participant).

"The Black men I know have come from Nigeria or from the West Indies or from Central Africa and they're not the same culturally. Some are Muslims and some are Christians. Some take drugs and some don't. So if you think about the person of Black skin as being like anybody else with `Black skin, I think that's a big mistake" (Professional Participant).

"Just acknowledging the importance of family intervention as a whole, bringing culture back in is even more important…to build that effective education within the family unit" (Professional Participant).

There is a critical need to re-distribute the power by involving people in their care in a meaningful way (to them) – this means both patients and their significant others. BAC men need to be seen as people beyond the prism of race, illness and diagnosis. Where appropriate, this should involve the patients' chosen advocates, who could be faith leaders.

This means all professionals, including mental health practitioners need to take time to reflect with and listened to patients, carers and staff who have been involved in detention process, to check if all parties have been heard and included in care decisions.

Creative approaches are integral to BAC people's healing and empowerment; therefore treatment options should include more choice for creative interventions such as music, poetry, spirituality. Other psycho-social/non-pharmaceutical interventions (e.g., mindfulness) should be made available as first choice, where appropriate to patients.

Clothing, hairstyle, and food are also integral to BAC men's culture, therefore care providers should respect and encourage individualised expression in these areas. A culturally appropriate Buddy system within inpatient settings should be systematically implemented, as many patients feel lonely and isolated while detained. Interventions should be open to family members as well – to support them while their loved one is detained and beyond discharge into the community/back with the family.

5.7. Reform the mental health assessment process

"Start with the people. Listen to who they are, what they need, to develop a care plan for them, do not try to fit them in already existing care packages" (BAC Participant).

"If we want to know what works, we really need to be asking the people we want to support." (Professional Participant).

"…the importance of spiritual understanding in MH services to that spiritual beliefs/practices are not misdiagnosed as psychotic symptoms" (Professional Participant)

There is a need to reform/re-evaluate the assessment tools and processes used and develop culturally appropriate tools that have been developed with and by BAC communities/researchers/practitioners.

There is a need to provide more time for mental health assessments during the detention process, e.g., a minimum of 2 weeks. The assessment tools and processes used and develop culturally appropriate tools that have been developed with and by BAC communities/researchers/practitioners.

The individual and their carer/loved one should have an equal input in the final decision making about detention and treatment. There should be a strong justification for the decision and shared with all parties. This will build reassurance within mental health assessments and address the power imbalance.

5.8. Medication

"Having been in the mental health system and now medication free, I see that practice ideas and the medical model is out-dated and broken…was told I would be on medication for life, but I am not and won't be. Medication isn't always the answer, communication and talking therapies are important. However, communication with people outside your own race can be difficult" (BAC Participant).

"The need for right (anti-psychotic) medication, for the right person, to meet the right need, at the right time" (BAC Participant).

"There is a legitimate suspicion of how medications are developed, what pharmaceutical companies real aims are and about the safety of medications […]

> *medications are generally developed and tested on White populations […] If you thought about the long-term, from the early stage and either got the dose right or minimised side effects to make it more tolerable […] then would almost certainly reduce the chance of readmission" (Professional Participant).*

There is a need for a transcultural system for administering psychiatric medication that accounts for the key physiological, metabolic, and psychological differences between males of different races.

This should include access to an independent, culturally trained pharmacist, advice and information that is independent from the ward, an advocate to say on the patient's behalf what the meds are doing, side effects, counter-indications, etc. Medication should be reviewed if a psycho-social intervention is chosen by the patient as the first treatment option to avoid unnecessary unpleasant side effects that may also disrupt the outcomes of the psycho-social intervention, e.g., flattening of emotions and disruptive thoughts. Non-pharmaceutical interventions seem to be the preferred options for BAC men.

These considerations were presented at the ImproveAct Parliamentary Symposium chaired by the lead of all party mental health think tank, Lord Bradley and opened by the Shadow Minister for Women's Health and Mental Health, Abena Oppong-Asare in Westminster in February 2024. The purpose of this event was to present the research considerations and co-produce an ImproveAct policy briefing. The ImproveAct policy briefing was presented at the ImproveAct dissemination conference in May 2024 and are included in the Policy and Practice Impact Case Study in this report.

6. Conclusion

The three ImproveAct themes concluded that mental health practitioners need to see beyond the monolithic racialised mask of BAC men and understand their identity through the lenses of spirituality, stigma, and the traumatic effects of racism to, *"make the experience (of detention) less de-humanising" (BAC Participant).* This requires putting the person before the practice.

This transcultural understanding and humility should be developed as training for all health and social care professionals who agree we should, *"…train people in cultural humility – it's not just culturally appropriateness but humility will help re-address the power balance. Your culture is not more right/more important than mine" (BAC participant).* Films were identified as an impactful tool to include in all training giving voice to the silences and complex nuances of risk perceptions.

To re-humanise detention, we need to first acknowledge and accept the Mental Health Act is out-of-date. To evidence this, the Conservative Government instigated reform of the Mental Health Act in 2017 and Commissioned the Independent Review of the Mental Health Act. The review identified a range of problems with existing mental health law, including increasing rates of detention across patient groups and poor experiences and outcomes from Black and Caribbean groups. The subsequent Mental Health bill received cross party support and formed part of the King's speech under the Labour Government (Bowman, 2023). Following this acknowledgement, we need to address the systemic power imbalances, misconceptions, and injustices currently operating within the detention process dictated by the out-of-date Mental Health Act

> *"The Mental Health Act as it stands is racist. We need more research to deracialize the Act" (BAC participant).*

Reigniting the Mental Health Act reforms and embedding within those a transcultural, recovery focused assessment, care and support model will help to radically reform a more equitable and inclusive Mental Health Act for all. *"It will take all colours to get out of this and work together for systemic change" (BAC participant).* That model must at its helm be co-produced by and for BAC men and their significant others; *"I am the data" (BAC participant)* and address the lack of BAC men's representation in drug testing.

These three themes highlight and represent the current systemic problems with the detention process whilst the eight considerations for policy and practice offer co-produced solutions and recommendations to these problems representing policy, practice, and future research.

Most of our policy and practice considerations mirror the recommendations from the Reforming the Mental Health Act paper in August 2021, (e.g., giving more rights about detention etc, exploring whether the use of CTOs is appropriate and fit for purpose) Everything that was highlighted in the White paper still stands and is now strengthened by our project findings.

7. Limitations

7.1. Methodological Limitations:

For rigour and transparency, it is vital all research reports the limitations of its study. Two pages of the report (pp. 7-8) are dedicated to explaining the challenges of conducting the narrative interviews with Black men and how the team overcame those by adapting EBCD from individual narrative interviews to art based-focus groups to capture the lived experience of Black men.

To summarise, the decision to change these came after piloting the film with one participant. Whilst they felt safe exploring their experience with the team during the interview and were very happy with the filming and edit of the interview, this changed when it came to showing their film. The participant did not 'trust' where the final film would/could go or be shared. Additionally, they felt the personal nature of disclosing their mental health condition could be detrimental to them if, for example, a future employee saw this.

Therefore, the research team had a moral obligation to re-assess the film method choice in light of ethical dilemmas including: the evidence around cyber security/data fraud threats, respect for privacy (especially regarding vulnerable subjects), and avoiding exploitation. This dilemma was brought to the Black community events where the community suggested/wanted to use art-based focus groups as an alternative option to the films. The findings of this described the detention process as suffocating, suppressing, reductionistic, depersonalized and inhumane.

It is important to acknowledge that there are a small number of papers that hold polar opinions to the EBCD findings above. For example, Solanki, et al. (2023) whilst interviewing 12 Black people found that the mental health interventions, they received were described sectioning alternatively, as a space for sanctuary and support. However, this was not the consensus of any of the Black men/significant other participants in ImproveAct. Nor was this a finding during our consultation of 200 stakeholders. The experience was described by Black men, their significant others and by professionals as *inhumane* hence, the ImproveAct

study reports it as the qualitative finding derived and named our 200 study participants as *inhumane*.

The majority of evidence emphasises the negative aspects of detention with participants viewing detention as a racist and racialized experience (Solanki, et al. 2023). However, this opposing finding may also be a limitation of the EBCD adaptation where idiographic accounts of Black men via the narrative interviews could not be captured. Therefore, it is possible that minority accounts where people did feel that restrictive powers were needed at a time they were most unwell because they posed a threat to their health and safety or the health and safety of others may not have been captured, as this went against the voice of the collective injustice in the focus groups and events. Future qualitative research should take idiographic accounts into consideration of the study design to explore this dichotomy in findings in more detail.

7.2. Contextualising the ImproveAct Findings:

It is important to note that this report, only provides a snapshot birds-eye overview of the ImproveAct findings. In this report covering the breadth of findings was more critical than the depth. There are (detailed in the dissemination section) multiple forthcoming ImproveAct papers with further evidence focusing on depth.

Significantly, the overall findings paper (Craig, E., et al. (n.d) '*ImproveAct: Considerations to Improve the Detention Experience by and for the Black Community'*) will delve deeper into the findings below. This will provide a richer, more detailed insight into the themes including how they interact, contradict, contrast, and compare with the current evidence, as well as contextualizing them within existing theoretical frameworks. Complimenting this, the methodological paper detailing the lessons learned from this study will be published in the subsequent methodological Improve-Act paper; Craig, E., et al. (n.d.) '*Working at the Speed of Trust: Adapting EBCD for Underserved Communities.*' This innovative paper will add to the growing body of knowledge in how to creatively adapt/improve current healthcare methodological approaches that are currently not fit for use with certain populations.

7.3. Scope of the ImproveAct Key Policy and Practice Recommendations:

The scope of Improve-Act was to bring everybody together, (i.e., stakeholders involved in mental health services and the detention process) to discuss emerging findings, identify further silences and key areas/actions to facilitate change. The community discussed how 'real change' requires some bold 'radical re-imagining' of current services. With over 200 people consulted, including Black men, health and social care professionals, policy and Governmental ministers and the Black community, the Improve-Act team co-created the following Policy and Practice Considerations. These are what the community see fit as possible solutions, that require further investigation, to tackling the mental health disparities facing Black men.

As this group of people have been underserved and silenced in research for so long the ImproveAct team felt it was vital to report these considerations as they were. This does mean putting cost implications aside. To not report the findings due to cost implications would again further silence and repress this community. Feasibility, piloting, contrasting and comparing these considerations with historic and existing examples, are all significant areas for future research that currently lie outside of the ImproveAct scope.

Patient and Public Involvement

PPI and co-production have been firmly embedded throughout this project, as evidenced throughout the report. Two people with lived experience (DB and KT) have been fully engaged in all the stages of the project, from conducting the systematic review, to data

validation workshops, writing and disseminating findings, speaking at conferences/parliamentary symposiums. It is not just their meaningful engagement in the research, but their personal growth and journey. One of the people with lived experience, DB, decided to re-start her academic journey and applied for a PhD scholarship with the support of a member of the ImproveAct research team. As a carer of a BAC man with experience of detention under the Mental Health Act, DB has also found her voice and inner strength to start advocating for the rights of people with similar experience, starting to work with other organisations such as ReThink Mental Illness and Greater Manchester Police.

As we stressed out above (section 4.2.3), the research team have faced and overcame systemic longstanding mistrust of the local BAC communities in services and academia/research which impacted on our ability to recruit BAC men for in depth one to one filmed interviews (a key component of EBCD methodology). We have reflected and explored best ways to engage with BAC men and their communities by speaking with community pillars and engaging in community led events. It was important to acknowledge people's mistrust and previous let downs directly and hear those concerns, as to not do so would be to repeat their previous experiences researchers and professionals that have only viewed them as data and confirm their mistrust. Our community engagement events in May and October 2023 were held in an effort to strengthen our rapport with BAC community. The events also acted as a reminder that, while there are many negative experiences of services, it is important to also acknowledge joy and celebrate the achievements that have been made.

We realised that a key missing ingredient from our recruitment strategy was creating a personal relationship with the community. We began to see success with our community engagement efforts when we let go of our fixed idea of what community engagement has to look like and approached engagement as people and not researchers. Instead of filmed interviews we held a creative workshop for BAC men and carers in October 2023, using poetry and art to explore emotion and feelings around mental health that are sometimes difficult to put into words. This workshop was hosted by a local BAC community pillar, SW, who was trusted and known by the community and ensured that she was involved in the creation process, from the design of the leaflet to the activities we did during the workshop, making the workshop just as much her success as it was ours. The follow up showcase event + focus group in November 2023 captured participants' inspiration and story behind their art/poem and speak more candidly about their experiences of mental health services.

Equality and Diversity

EDI core principles have been taken account when undertaking the ImproveAct project and reporting its results (here and elsewhere).

The use of language was particularly important in this project. We paid particular attention to feedback from people with lived experience regarding acceptable terminology in our dissemination events, writing and/or discussions and meetings.

This project is already addressing a significant health inequality for BAC men disproportionally detained under the Mental Health Act, therefore there was no particular need to explore or present the results to indicate differences between groups based on the level of burden and poor experiences associated with this systemic issue. The purpose of the project was to identify ways in which support and services, and eventually experiences can be improved.

We have used drawings and lay summaries when we presented our themes, as well as using music, art and food to make our events comfortable, safe, accessible and enjoyable by

our participants. Once this report is peer reviewed and accepted for publication, we will produce an accessible summary of the findings, including short films.

Our research team was diverse, including co-applicants and people with lived experience of detention or caring for somebody who has been detained, who have contributed to the project throughout, including co-developing and presenting findings at a wide range of events. Our team was carefully put together to reflect a wide range of expertise and experience, including all genders, ages, expertise regarding the methodology (e.g., EBCD, Silences Framework, co-production), the topic (e.g., detention under the Mental Health Act, racial inequalities, human rights), experience of having managed or contributed to previous NIHR funded studies, experience of being a BAC man detained under the MHA or caring for somebody who is/has been, experience as practitioners/social care professionals engaged in the mental health detention process. Junior Research Assistants were supported in developing their skills and experience, including attending training, developing posters/briefings, presenting findings at national and international conferences, and contributing to emerging peer reviewed papers.

We have troubleshooted problems and appeased tensions along the way. We stopped and reflected who we were as individuals, whether Black or White, as researchers, and as a team, reflected on why we came together on this journey, learnt from our mistakes and came out stronger to deliver to the project's objectives. Our team has considered their positionality during the ImproveAct research management group (RMG) meetings, as well as during a key Anti-racism and intersectionality workshop which was led by 2 BAC men, co-applicants, one of them with generational experience of detention under the MHA. The workshop highlighted the historical context of racism in mental health services, the ways this history impacts research. The workshop gave co-investigators a better understanding of everyone on the research team and how their own experiences influence their practice. This workshop displayed the research team's commitment to consistently reshaping their practice and conducting research in a way that is culturally informed.

Outputs from the Project

We have delivered a wide range of outputs part of the ImproveAct research programme, including conference presentations, webinars, university lectures, workshops with people with lived experience, blogs, etc, e.g.,

- Lived experience workshop to discuss and validate systematic review protocol [November 2021]
- Parliamentary symposium [February 2022]
- Follow up (2nd) lived experience workshop systematic review [April 2022]
- Follow up (3rd) lived experience workshop systematic review [July 2022]
- A 2-day writing retreat lived experience systematic review [September 2022]
- Conference presentation: Hearing the silences: putting lived experience at the heart of research [October 2022]
- Lecture to mental health students at MMU: Mental health detention, inequalities and the ImproveAct project [December 2022, December 2023]
- Anti-racism and intersectionality workshop [May 2023]

- ImproveAct Mental Health Community Celebration Event [May 2023]
- ImproveAct workshop at the N8 Policing Innovation Forum 2023: IMPROVING POLICING FOR BLACK PEOPLE: THE RACE ACTION PLAN [June 2023]
- Police workshop on mental health detention and inequalities [August 2023]
- ImproveAct Policy Roundtable [September 2023]
- Bergqvist A. Shared Decision-Making and Relational Moral Agency: On Seeing the Person Behind the 'Expert by Experience' in Mental Health Research. Royal Institute of Philosophy Supplement. 2023;94:173-200. doi:10.1017/S1358246123000243 [September 2023]
- Conference presentation: Mental Health Professionals Experiences of Supporting UK Black African-Caribbean Men Detained Under the Mental Health Act 1983
- Webinar: Leah, C. and King, C.(2023). Anti-racist perspectives and the AMHP role – taking professional responsibility to address racism in practice. DHSC Chief Social Workers Office in conjunction with the British Association of Social Workers
- Conference presentation: Improving the Patient Experiences of African Caribbean Men Detained Under the Mental Health Act: Working Towards a Co-produced Intervention Using the Silences Framework (ImproveAct) [October 2023]
- Lived experience community creative workshop [October 2023]
- PhD Application for person with lived experience: DB's application for a White Rose Doctoral Training Partnership for a funded PhD on the wellbeing, health and communities pathway [October 2023]
- Leah, C. (2023). ImproveAct Research: Supporting Black and African Men's detention experiences – reflections for AMHP practice. National AMHP Conference - Research Informed Practice and Practice Informed Research (online).
- DHSC Blog on ImproveAct (Twitter) [November 2023]: (impact): https://socialworkwithadults.blog.gov.uk/2023/11/16/promoting-progressive-amhp-anti-racist-practice/
- Lived experience community showcase event and focus group [November 2023]
- Heyes et al. (*n.d.*) Experiences of Black male detention under mental health legislation: Challenging the systematic review through the Silences Framework [Journal article]. Currently under review at PLOS Mental Health [re-submitted December 2023].
- ImproveAct Co-design event [February 2024]
- ImproveAct Westminster Parliamentary Symposium: ImproveAct- BAC Men and the Mental Health Act: What's next on the reform agenda? [March 2024]

Policy Relevance

Findings from this research were co-created, contextualised and disseminated using a strong PPI and Policy approach. Our collaboration with people with lived experience and with the cross-party think tank, Policy Connect, were key to the success of this project. Policy Connect have successfully delivered 2 symposium events, 1 roundtable event, 1 Policy Briefing Paper and a series of meetings with policymakers. The last policy symposium, in Westminster, marked a pivotal moment as we collectively considered reforms to the Mental Health Act, with the aim of fostering greater equity, understanding, and support for BAC men navigating mental health challenges in our society. Participants discussed the importance of systematic and legislative reform that delivers equitable access to care by prioritising transparency, effective communication, and humanised, culturally competent mental health support.

Questions/suggestions for future research:

Further research should be commissioned to:

- develop appropriate methodologies to both engage with underserved communities and capture the lived experience (e.g., trauma, racism, etc.) of a community rather than focusing only on individual stories; this includes developing and implementing ethical procedures that are accessible, non-jargonistic, that do not intimidate potential participants; as well as funding and academic systems enabling meaningful participation from people with lived experience, specifically from people on benefits;
- develop community-based, community-led therapeutic interventions that tackle generational and community trauma (e.g., art-based, creative methods);
- explore and better understand the line between psychosis and spirituality to help clinicians with decision making, especially regarding detention and diagnosis;
- investigate reasons for detention under the Mental Health Act for BAC men (to identify whether alternative options would have been more appropriate and lessons learnt);
- explore what is specific to BAC men's wellbeing and recovery from ill mental health to co-design appropriate interventions that match their needs.

Key recommendations included in the ImproveAct Policy Briefing:

1. To ensure ***culturally competent care***, develop humility training in collaboration with mental health professionals, including police officers, focusing on diverse cultural perspectives. This multidisciplinary approach will integrate cultural awareness into existing frameworks with support from organisations like the Royal College of Psychiatry and the Royal College of Nursing. Additionally, address resource gaps and combat intrinsic racism by tailoring training sessions to tackle institutional racism and systemic oppression within police forces.
2. To ensure ***inclusive mental health support***, establish core specifications for community-based Mental Health Hubs focusing on psychosocial approaches and creative practices. These hubs, following a community support model, will integrate

culturally relevant services through collaboration with faith leaders and community organisations. Modern technology will be utilised for accessibility and engagement, ensuring these hubs serve as safe spaces for BAC men to address isolation and foster social connections.

3. To ensure ***effective advocacy and complaints mechanisms*** in mental health care, extend cultural advocacy across legislation, recognising its role beyond legality to represent individual needs and promote recovery. Address biases through human rights-based approaches and improve reporting mechanisms for incidents of racism and discrimination. Promote partnership working to empower communities and individuals in advocating for equitable access to mental health services.
4. To ensure that ***trust between the police and BAC communities*** is rebuilt, implement national strategies like the "right care, right person" approach and race equality action plans. Provide training to police on recognising and addressing PTSD symptoms, acknowledging, and addressing the fear and triggers associated with police interactions among BAC men.
5. ***Revise the Mental Health Act assessment process*** to prioritise positive outcomes and strength-based approaches, incorporating individual needs, cultural understanding, and spiritual beliefs. This should be done by challenging institutional biases against BAC men, advocate for transcultural medication frameworks, and develop culturally sensitive medication practices with healthcare professionals. Furthermore, introducing advanced choice documents for individuals to express care preferences, reducing detention risk and promoting culturally appropriate advocacy.

Key Policy Recommendations:

After conducting comprehensive research, it has been unequivocally concluded that the core recommendation is that ***lived experience must be placed at the forefront of research, policymaking, and reform processes within the mental health sector***. The research highlighted a critical gap in resources and infrastructure for accessing individuals with lived experience, hindering the confidence of stakeholders, including researchers, policymakers, and mental health boards, to drive systemic reform. Conversely, individuals with lived experience express a strong desire to play a central role in the reform process, beyond merely being subjects of study. They seek genuine empowerment to lead and influence change within mental health systems, ensuring that their voices are heard and acted upon.

To address these findings and facilitate tangible change, we recommend the establishment of a ***Lived Experience Commissioning Group/Council***. This commissioning group, modelled after the successful Disabled Student Commissioning Group, will serve as an independent consultancy body, advising key stakeholders such as the Care Quality Commission (CQC), Department of Health and Social Care (DHSC), policymakers, and leading mental health boards across the nation. With an initial budget allocated for three years, this group will be co-chaired by an officially appointed Mental Health Ambassador to signify endorsement from the DHSC. Comprising ten full-time paid positions filled by individuals with lived experience including BAC men who have experience of having been detained under the Mental Health Act, the commissioning group will possess the authority to provide guidance, scrutinise policies, commission focused research, and enact meaningful changes within the mental health sector. These individuals will rotate periodically to prevent trauma and burnout and ensure diverse leadership.

Specifically, the group will focus on advising, informing, and challenging the mental health service/commissioners' sector to enhance support models for individuals experiencing crisis, particularly those detained under the Mental Health Act. Additionally, the commission will identify and promote effective practices to ensure positive experiences for individuals detained under the Mental Health Act. The primary objective of the Lived Experience Commissioning Group is to enhance the experiences of individuals with mental illness within mental health care settings, with lived experience at the forefront of reform efforts. The group would advocate for:

- Improved support models for individuals experiencing crisis, particularly those detained under the Mental Health Act.
- Identification and promotion of effective practices to ensure positive and successful experiences for individuals detained under the Mental Health Act. Additionally, the commissioning group would have a dedicated section with allocated funds to concentrate on resources to address issues of racism, disparities, and detention rates, with a particular emphasis on the experiences of BAC men detained under the Mental Health Act.

This Commissioning Group will also serve as a race and mental health advisory group to the CQC, offering insights on improving its monitoring functions concerning the Mental Health Act's impact on BAC men. It would serve as a race and mental health advisory group to the CQC, offering insights on monitoring the Mental Health Act with regard to BAC men and other minority groups.

Dissemination

ImproveAct outputs that have already been disseminated during the lifetime of the project have been captured in Section 9 above.

Current/upcoming events and plans for dissemination include:

- Leah, C. (2024) International Conference of Law and Mental Health, Lyon. Mental Health Professionals experiences of detaining Black men under the Mental Health Act 1983- A call for anti-racist assessment practice [Conference presentation]
- Leah, C. (2024). World social work day presentation to qualified social workers nationally. Improving the Act – anti-racist social work practice – lessons from research [Conference presentation].
- Dixon, J & Leah, C. (2024) European Sociological Association Conference. 'I don't think there's many Black African Caribbean men that talk positively about mental health services': Mental Health professionals' perspectives on distrust amongst Black men detained in psychiatric hospitals. [Conference presentation]
- Leah, C. (2024). World social work day presentation to qualified social workers nationally. Improving the Act – anti-racist social work practice – lessons from research.
- ImproveAct Conference: 21st May 2024

- Anna Keynote Speaker: 25th INPP Annual Conference *Crisis and Mental Health*, Sigmund Freud University Vienna, 23-25Tn May 2024: https://conference2024.at/ (building on recent creative paper: https://academic.oup.com/edited-volume/46864/chapter/421436904?searchresult=1)
- Dixon, J., and Leah, C., (2024) 'I Don't Think There's Many Black African Caribbean Men Who Talk Positively About Mental Health Services': Mental Health Professionals' Perspectives on Distrust Amongst Black Men Detained in Psychiatric Hospital, European Sociological Association, Porto University, 27.08.24.-30.08.24.

The project has been successful in generating impact via the use of social media, blogs, and press releases. Exposure of these from the MentalElf has generated substantial nation-wide impact. The MentalElf is an innovative digital platform that helps professionals keep up to date with simple, clear, and engaging summaries of evidence-based research. The MentalElf shared our blogs, press releases and live reported our ImproveAct Co-design event, our Parliamentary Symposium and will be live reporting our ImproveAct conference in May 2024. The conference is still to take place so the metrics following so not include conference impressions. However, in total these events engaged 106 online social media attendees who tweeted a total of 439 Tweets. Those tweets then went on to have 21.6 million hashtag impressions. Impressions indicate how many times a tweet/hashtag has been viewed and is calculated by adding the actual number of impressions for each tweet in the report.

The ImproveAct conference took place on the 21st May 2024. We had105 delegates who attended including people with lived experience, health and social care professionals who work in the detention field, third sector BAC mental health charities and advocates, legal experts, the police and mental health and racial disparity researchers. The other four studies funded under the same NIHR call were invited to share their findings also. Only the FINCH study could attend but they shared two sessions with delegates. This conference was not only be educational, and informative, but it was a creative, immersive day that showcased the BAC art and poetry created from the ImproveAct FGs. The conference ended with a final call to action, engaging every colour, profession and experience to campaign for radical reform of the Mental Health Act.

Following the conference MMU's press team will be covering the journey of the ImproveAct and the findings and showcasing this to their research community. This press release will be shared on all social media platforms for full exposure and visibility.

With regards to further policy impact and dissemination this will be achieved by our ongoing partnership with Policy Connect through:

- Engaging Luciana Berger through the upcoming Policy Connect event on Maternal Mental Health, inviting her to review the briefing paper and organising a follow-on meeting alongside Lord Bradley.
- Participating in the parliamentary launch of the Black Mental Health Manifesto, authored by a coalition of Black-led grassroots organisations, race equity leaders in the mental health sector, individuals, and activists.
- Publishing written a blog piece during the re-election period to continue engagement and prepare for a new government after the General Election.

Forthcoming/peer reviewed publications include:

- ImproveAct EBCD findings, three themes and recommendations – overall paper. To be submitted to *BMJ Open or Frontiers in Psychiatry*
- Leah.C, et al. (n.d.) Reframing the detention experience of Black Men under the MHA: what is the most beneficial? To be submitted to the *British Medical Journal Mental Health*
- Dixon J, et al, (n.d.) Trust, BAC men and MH detention. To be submitted to *Psychiatric Services or Transcultural Psychiatry*
- Hayes et al., (n.d.) Paper with people with lived experience: Perspectives of co-production. To be submitted to *BMC Research Involvement and Engagement*.
- A methodological ImproveAct paper; Craig, E., et al. (nd.) 'Working at the Speed of Trust: Adapting EBCD for underserved Communities.' To be submitted to *BMJ Mental Health or International Journal of Qualitative*
- A theoretical ImproveAct paper Craig, E., et al. (nd.) 'Beyond the Voice': From Silence to Soap Box'
- An epistemological paper: Bergqvist, A, et al (nd.) Racism as an Epistemic Injustice in Psychiatry.

Actual and anticipated impact

The ImproveAct project has been successful in generating impact via parliamentary symposiums and round table sessions, conference presentations, seminars/webinars attended by a wide range of audiences, including academics, practitioners, people with lived experience and their carers, students, and the public. Impact beyond practice and academia has also been achieved via the use of social media, blogs, and press releases. Exposure via MentalElf has generated substantial nation-wide impact, with evidence of engagement from 106 online social media attendees who tweeted a total of 439 Tweets. Those tweets then went on to have 21.6 million hashtag impressions. The upcoming ImproveAct conference, with 100+ attendees currently registered will showcase findings from other NIHR studies funded under this call, including the Finch Study and ImproveAct. registered to attend including people with lived experience, health and social care. This engaging creative conference will be a final call to action, engaging every colour, profession and experience to campaign for radical reform of our mental health act. This will be a platform for dissemination, discussion, celebration and remembrance for the lives of BAC men lost to mental health detention.

Detailed information about actual and expected impact (short and long term) is presented in the added value examples sent with the report.

Intellectual Property (IP) and commercial adoption

No IP outputs are expected to arise from this research.

Appendices

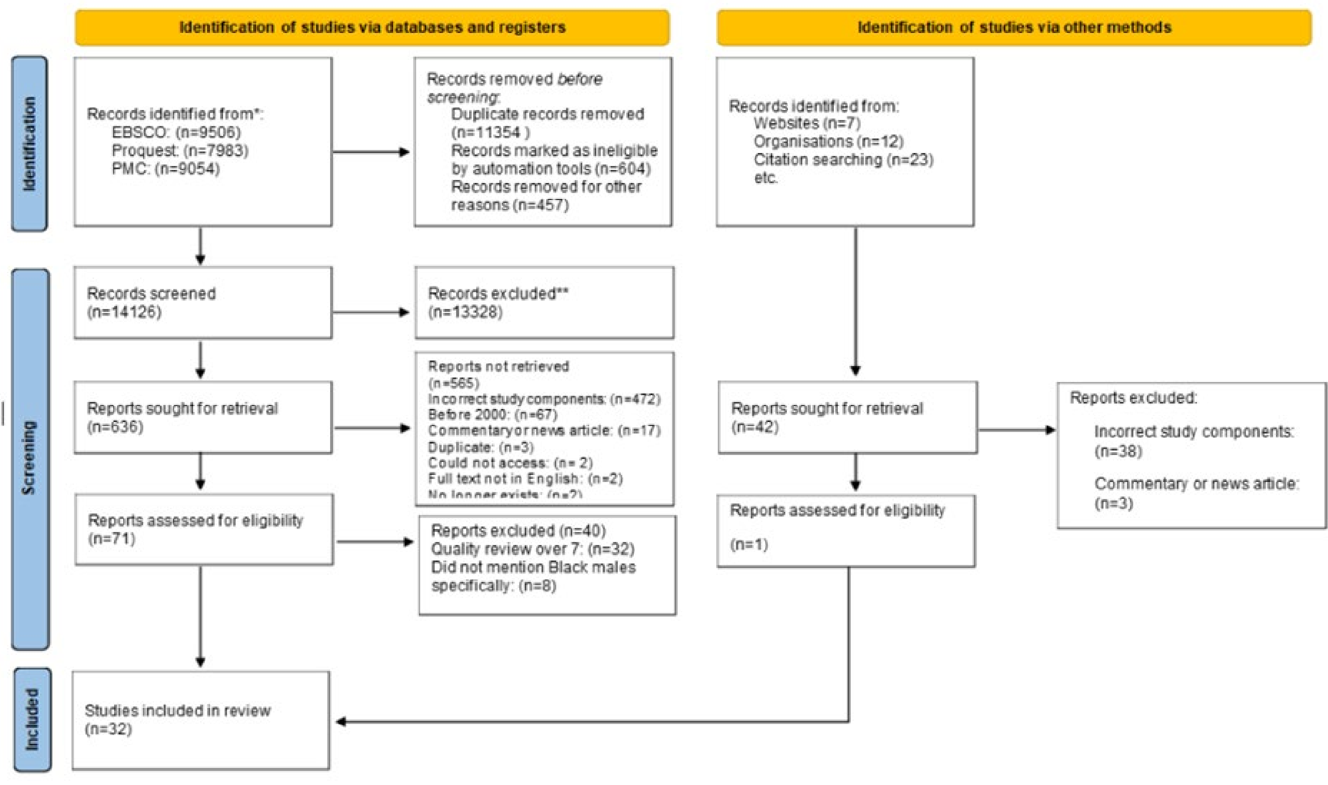
Appendix 1: ImproveAct Systematic review initial searches

EBSCO	
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental disorder” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND (Detention OR detained OR incarcerated)	48
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND (Detention OR detained OR incarcerated)	48
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND ((“police detention” OR detention))	7
((“black men” OR BAME OR “black man” OR ethnicity OR “black adult male”)) AND ((“Mental Health” OR “mental illness” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((Detention OR “involuntary hospitalisation”))	148
(("black men" OR "black males" OR "african american men")) AND ((“Mental Health” OR “mental illness” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((Detention OR “involuntary hospitalisation”))	20
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR ethnicity OR “black adult male”)) AND ((Detention OR “involuntary hospitalisation”))	148
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR “black man” OR “black adult male”)) AND ((Detention OR “involuntary hospitalisation” or "involuntary hospitalization"))	6
(("black men" OR "african american men" OR "black males")) AND (("mental health" OR "mental illness" OR "mental disorder" OR "psychiatric illness")) AND ((Detention OR "involuntary hospitalisation" OR “involuntary hospitalization”))	10
(((black OR african OR afri OR Caribbean OR BME OR BAME OR minority OR ethnic OR ethnicity OR race OR racist OR racial) AND ("mental health" OR "mental health act" OR psychiatry OR psychiatric)) AND (detention OR detain OR custody OR incarceration OR incarcerated OR compulsory OR sectioned OR "Section 136" OR "Section 135" OR "Section 2" OR "Section 3"))	3,081
(((((black) OR (BME)) OR (afri*)) AND (mental health)) AND (hospital)) AND (detention)	61
(((((BME) OR (minority groups)) AND (black)) AND (mental health act)) AND (detention)) AND (hospital)	5
Black AND male AND (“mental health” or “mental illness” or “mental disorder” or “psychiatric illness”) AND (Detention OR Incarceration OR Hospital OR Section*)	3,995
Black AND male AND (“mental health” or “mental illness” or “mental disorder” or psychiatric illness”) AND (Detention OR Incarceration OR Hospital OR Sectioned)	1,929
ProQuest	
Ab((“Mental Health” OR “mental illness” OR “mental stability” OR “mental disorder” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND Ab (Detention OR detained OR incarcerated)	114
Ab((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND Ab (Detention OR detained OR incarcerated)	129
Ab((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR “black person” OR “black adult male”)) AND Ab((“police detention” OR detention))	22
((“black men” OR BAME OR “black man” OR ethnicity OR “black adult male”)) AND Ab ((“Mental Health” OR “mental illness” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND Ab ((Detention OR “involuntary hospitalisation”))	310
(("black men" OR "black males" OR "african american men")) AND Ab ((“Mental Health” OR “mental illness” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND Ab ((Detention OR “involuntary hospitalisation”))	36
((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR BAME OR “black man” OR ethnicity OR “black adult male”)) AND ((Detention OR “involuntary hospitalisation”))	207
Ab((“Mental Health” OR “mental illness” OR “mental stability” OR “mental balance” OR “mental disorder” OR depression OR “mental sickness” OR “emotional disorder”)) AND ((“black men” OR “black man” OR “black adult male”)) AND Ab((Detention OR “involuntary hospitalisation” or "involuntary hospitalization"))	21

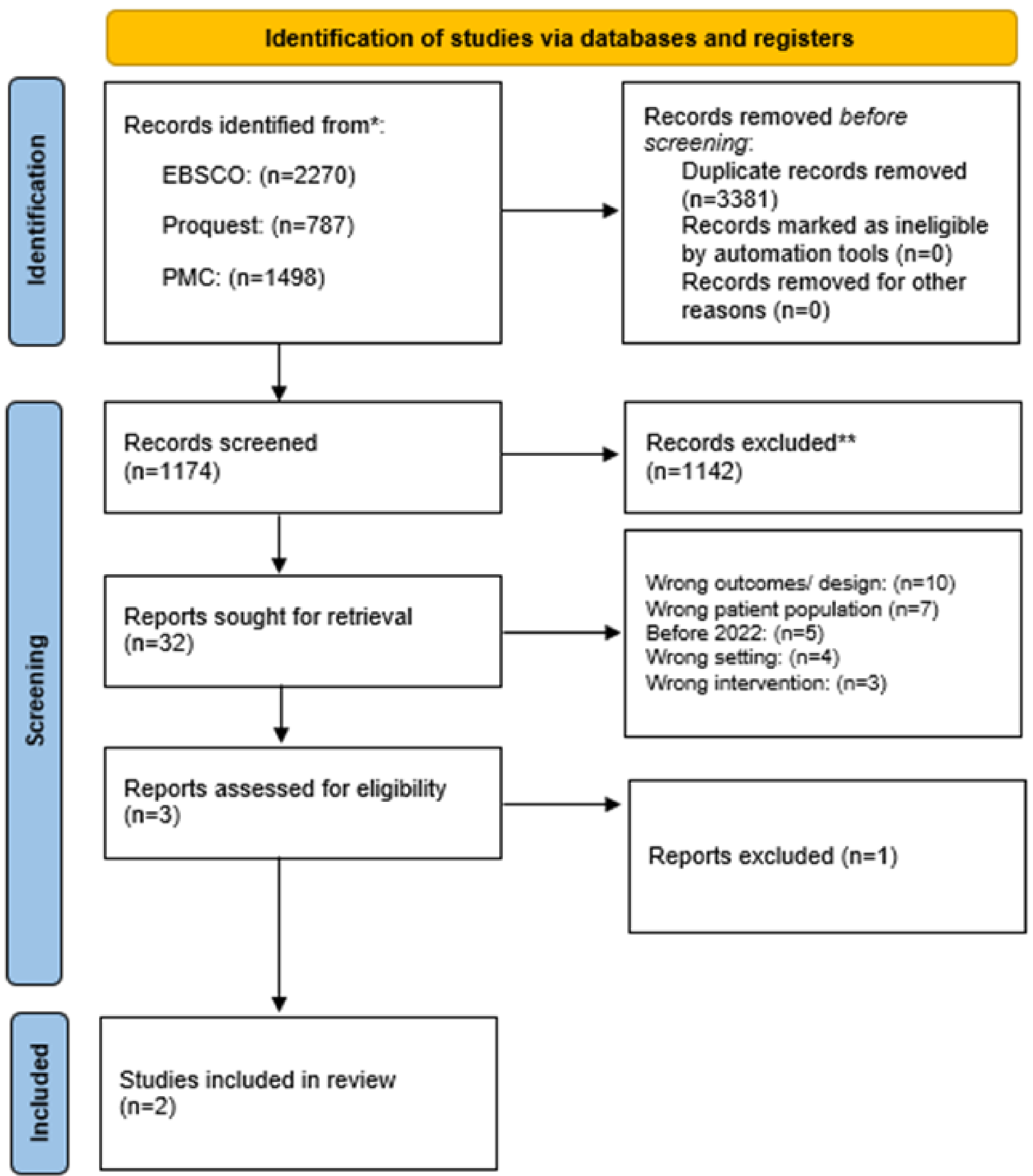
(("black men" OR "african american men" OR "black males")) AND Ab(("mental health" OR "mental illness" OR "mental disorder" OR "psychiatric illness")) AND Ab((Detention OR "involuntary hospitalisation" OR "involuntary hospitalization"))	31
(black OR african OR afro OR Caribbean OR BME OR BAME OR minority OR ethnic OR ethnicity OR race OR racist OR racial) AND ("mental health" OR "mental health act" OR psychiatry OR psychiatric) AND (detention OR detain OR custody OR incarceration OR incarcerated OR compulsory OR sectioned OR "Section 136" OR "Section 135" OR "Section 2" OR "Section 3")	2,082
(((((black) OR (BME)) OR (afri*)) AND Ab(mental health)) AND (hospital)) AND (detention)	26
(((((BME) OR (minority groups)) AND (black)) AND Ab(mental health act)) AND (detention)) AND (hospital)	5
Black AND male AND Ab ("mental health" or "mental illness" or "mental disorder" or "psychiatric illness") AND Ab(Detention OR Incarceration OR Hospital OR Section*)	3,296
Black AND male AND Ab("mental health" or "mental illness" or "mental disorder" or psychiatric illness") AND Ab(Detention OR Incarceration OR Hospital OR Sectioned)	1704
PMC PubMed Europe	
(("Mental Health" OR "mental illness" OR "mental stability" OR "mental disorder" OR "emotional disorder")) AND (("black men" OR BAME OR "black man" OR "black person" OR "black adult male")) AND (Detention OR detained OR incarcerated)	475
(("Mental Health" OR "mental illness" OR "mental stability" OR "mental balance" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND (("black men" OR BAME OR "black man" OR "black person" OR "black adult male")) AND (Detention OR detained OR incarcerated)	524
(("Mental Health" OR "mental illness" OR "mental stability" OR "mental balance" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND (("black men" OR BAME OR "black man" OR "black person" OR "black adult male")) AND (("police detention" OR detention))	158
(("black men" OR BAME OR "black man" OR ethnicity OR "black adult male")) AND (("Mental Health" OR "mental illness" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND ((Detention OR "involuntary hospitalisation"))	1,554
(("black men" OR "black males" OR "african american men")) AND (("Mental Health" OR "mental illness" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND ((Detention OR "involuntary hospitalisation"))	196
(("Mental Health" OR "mental illness" OR "mental stability" OR "mental balance" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND (("black men" OR BAME OR "black man" OR ethnicity OR "black adult male")) AND ((Detention OR "involuntary hospitalisation"))	1,554
(("Mental Health" OR "mental illness" OR "mental stability" OR "mental balance" OR "mental disorder" OR depression OR "mental sickness" OR "emotional disorder")) AND (("black men" OR "black man" OR "black adult male")) AND ((Detention OR "involuntary hospitalisation" or "involuntary hospitalization"))	131
(("black men" OR "african american men" OR "black males")) AND (("mental health" OR "mental illness" OR "mental disorder" OR "psychiatric illness")) AND ((Detention OR "involuntary hospitalisation" OR "involuntary hospitalization"))	180
("black" OR "african" OR "Caribbean" OR "BME" OR "BAME" OR "minority" OR "ethnic*" OR "race") AND ("mental health act" OR "psychiatry*") AND ("detention" OR "detained" OR "incarcerat*" OR "compulsory" OR "section*") AND (FIRST_PDATE:[1983 TO 2023])	2,414
(((((black) OR (BME)) OR (afri*)) AND (mental health)) AND (hospital)) AND (detention)	1,352
(((((BME) OR (minority groups)) AND (black)) AND (mental health act)) AND (detention)) AND (hospital)	288
Black AND male AND ("mental health" or "mental illness" or "mental disorder" or "psychiatric illness") AND (Detention OR Incarceration OR Hospital OR Section*)	228
Black AND male AND ("mental health" or "mental illness" or "mental disorder" or psychiatric illness") AND (Detention OR Incarceration OR Hospital OR Sectioned)	228 (same as above)

Appendix 2: ImproveAct Systematic review PRISMA charts (original and final)

Original ImproveAct Systematic Review PRISMA Flowchart



Final ImproveAct Systematic Review PRISMA Flowchart



Appendix 3: ImproveAct Systematic Review Table of Table of Initial Themes and Subthemes

Themes	Sub-themes
Environment and Practice; This theme explores practise within mental health services.	• Oppressive practice • Poor practise • Violent practise • Excessive prescribed drugs • Wrong medication • Black patients are treated as inferior • The care given to Black patients is poor • Why do Black patients present with ‘unusual behaviour? • Racial abuse from staff and patients • Data protection • Rules and regimes • Quality of training and practise • More complex pathways for Black men • Black men more likely to be in medium and high secure services • Over representation of police detention • Cultural appropriate treatment • Diet and food as part of holistic treatment • Professional teams are not curious about patients • Lack of empathy • Bias again Black people – preconceived ideas • Psychiatric abuse • Does the individual agree with their diagnosis? • Challenging your care
Identity: This theme highlights how different identities', on top of race, can influence treatment in and experiences of services, and explores how identity is presented within research.	• Black men more likely to be younger and have longer hospitalisations • Black people are seen as a monolith and defined as one category • Colourism, Black people treated differently depending on how light or deep their skin tone is • Class • Neurodiversity • Physicality • Culture and traditions • Spirituality • Religion • Family
Language and Communication: This theme explored how language used by professionals and a lack of communication between them and patients and carers contribute to poor	• Clinical gaslighting • Intersectionality • Language barriers • Human rights and international law • Family’s role in care • Advocates and support with no family • Understanding the diagnosis • Accountability

experiences of mental health services.	
Power and First Order Practise and Professional Curiosity: This theme explored how power held by the professional and by mental health services supersede patients and carers and the preference for first order, blanket rules over person centred, case-by-case decision making.	• Elitism • Class • Hierarchy • Patient led and patient consulted care • Lack of insight into care • Patients being criminalised • Under-diagnosis of non-psychotic disorders • Over diagnosis of psychotic disorders • Element of ‘working out' missing from services, lack of curiosity about the whole person • Separating the person and their mental illness as they are not one and the same

Appendix 4: Methodological Triangulation Initial Themes and Subthemes Padlet

The Padlet can be viewed by scanning this QR code. Below are the exported themes generated on the Padlet.

Post number	Subject	Body
1	INJUSTICE - red is the blood that was shed	(LE) No justice = Mistrust in authority, Fear of authority. When in need of help the default is to turn to local support systems instead of authority figures or professionals (LE) This mistrust/injustice form the negative social narrative engrained in the black communities stemming from multiple generations of oppression and slavery (LE) The blood that was shed from white people taking black people in slavery and colonisation runs deep in the ancestral community (LE) This leads to inter-personal trauma (LE+PFS) Professionals need to understand the factors correlated with a higher prevalence of mental illness in BAC men, e.g., the impact of poverty, substance and alcohol misuse, crime, trauma, abuse and discrimination etc. (LE+PFS) BAC men may have issues in trying to rediscover their voice after life experiences have made them believe silence was safer.

2	IDENTITY - from men to man	(LE) Change from the black men project to knowing and understanding the Black man as an individual (LE+PFS)The many multi-dimensions of the individual Black man e.g. religion, class, disability, gender, sexuality, culture etc.. (LE) Need to be heard (LE) Need to be understood (LE+PFS) Need for person centred care not just racial or gendered care (LE+PFS) Weight of racism that informs your identity (dripping tap of systemic micro and macro generational oppression) The true weight of trauma as a black man that shapes/forms/changes your identity (LE+PFS) When men feel listened to, heard and understood by a professional who is more representative of who they are, that can go a long way in building therapeutic connections and aiding recovery (LE+PFS) Black are often treated monolithically by police and mental health services, with little consideration for the cultural and traditional differences within the Black community. (LE) Being treated like human is an essential 'health equality' – access to good mental health support shouldn't be linked to wealth, status or background;

3	RACISM	What is racism? (e.g. Daily. Constant. Fear of. Living in trauma) (LE) Effects include tired, angry, stressed, fear, constant anticipation and expecting racism (PFS) Healthcare professionals do not feel comfortable using language around 'race'. (e.g. is it ok to describe someone by their skin colour?) This (CL edit 'might') block communication and (might) stop (it's more subtle than this - CL) from building a rapport with people. (LE) Need to consider conscious and unconscious bias in professionals, to challenge racism in practice. For practice to be truly progressive and based on human rights, it need to include reporting and logging incidents of racism (CL) agree - this should be an action for improvement. (LE) Racism is making us sick This all links with INJUSTICE - Possible sub-theme under RACISM. or Racism possible sub-theme under INJUSTICE . Two are very intrinsically interlinked (LE) Experiences of racism/anti-Blackness (CL - Whiteness) being pathologized and part of ones mental health diagnosis.

4	SUPPORT - Embed in all themes	(LE) some types family, religious community, ancestors (LE) Look to them for wisdom, loyalty, (LE) What support you look for: stand with and hold up (LE) Stand With - in times of need and injustice (LE) Hold Up - speaks of the tiredness when you can no longer stand alone. No-one should stand alone (LE) Accepting of vulnerability, unafraid of vulnerability (PFS) Many families go out their way to 'hide' their men who are struggling with mental health due to the stigma, distrust and negative social narrative around mental health services. This is seen as an example of support (PFS) Need to involve/explain the Mental Health Act to family/friends (PFS)Need to be included in loved ones care (PFS) Poor awareness of good services in the community (LE+PFS) Role of family – key in both challenging the service (where poor practice) and supporting their loved ones in their recovery. (LE) "As men we must..." Support created inwardly, community focused as opposed to individualistic framing of mental health support. "We" instead of "I"

5	MENTAL HEALTH	(LE+PFS) Should be needs led and trauma informed. Start with the people; listen to who they are, what they need, to develop a care plan for them, do not try to fit them in already existing care packages; (LE+PFS) post-discharge meetings should explain and support healing around the detention experience and any trauma experienced on the ward (LE+PFS) joint decision making (LE+PFS) give back some power - rebalance the power by giving people choice in the care planning (LE+PFS) Whiteness in the mental health system (LE+PFS) Care path should begin in the community then pre-detention all the way through to post-discharge (LE+PFS) "Aftercare needs to be more intense...just thinking what's going to benefit the person. Do they need to stay on home treatment for longer? Do they need a Black worker? Do they need someone who understands their ethnic background and cultural differences to support them?" (LE) Need for family access, inclusion and involvement (LE+PFS) Needs to be a change in societal narratives. Black men not encouraged to seek help (LE+PFS) The nature of medical assessments does not necessarily draw on transcultural psychiatry. (LE+PFS) MH should be embedded in the community - Community based support is key – best space to open up, un-silence silences, re-build trust in oneself, the community and support services; (LE+PFS) People experience trauma because of the detention experience - creates a vicious cycle of ill mental health (LE+PFS) Politics of outdated MHAct and detention process - links to power theme (LE+PFS) Assessment and Interventions are not always culturally adapted for the needs of Black men - diagnosis - needs to be informed by transcultural psychiatry (LE+PFS) Many of the therapeutic interventions are idiographic (e.g. cognitive behavioural therapy) need for radical change to adapt interventions to include social factors cause ill mental health (e.g. racism, injustice, poverty, substance use etc) (LE+PFS) Need to diversify the health care workforce (LE+PFS) Radical change is needed to fix a broken system

		From Support Theme below: (PFS) Need to involve/explain the Mental Health Act to family/friends (PFS)Need to be included in loved ones care (PFS) Poor awareness of good services in the community (LE+PFS) Role of family – key in both challenging the service (where poor practice) and supporting their loved ones in their recovery.

6	MISCONCEPTION - (includes risk or danger)	(LE+PFS) Aggression/danger/risk needs to be understood from both perspectives (the professionals and the men with lived experience) (LE+PFS) Black men have a stigma of being aggressive - need to understand the root cause of their aggression ie. the protection of self due to generational racism, injustice and the societal narrative of people being tazered and restrained leading to death historically (LE+PFS) The act of being detained involves the black men being the victim of violence/aggression. If they then are being detained again aggression may be an innate reaction to protect themself from the original violence/aggression they experienced in the 1st instance (LE) need to explore the different perspectives of 'risk'. Who is protecting who from what risk during detention?

7	POWER	(LE+PFS) Detention is enforced on someone (LE+PFS) The language and communication during and after detention is jargonistic. People have no idea what's happening to them or why (LE) Need to humanise the detention process and humanise communication (LE+PFS) Pathways to care are hidden (LE) Want to be free from control (LE) Power is stripped from the individual being detained. (LE+PFS) Detention process is dominated by Mental Health Act. The process is very arbitrary it doesn't take the 'person' into account. This demonstrates the black men have a power disadvantage over healthcare professionals but also healthcare professionals have a power disadvantage over the outdated policies/acts/assessments dictating how they do their job (LE) Family/loved ones/carers worried that voicing their complaints will affect the care of the person in services

8	RELIGION / SPIRITUALITY	(LE) Current biomedical model biased towards Christian beliefs (LE) Religion is where some black people/communities turn to for support (LE) Communities may be shy in coming forth with their religious beliefs as they are contrary to the Western mental health model (e.g. hearing voices, praying to higher powers, receiving wisdom from higher powers etc)

9	MEDICATION	(LE+PFS) Medication is tested on White populations leading to mistrust of mediation and its efficacy on the Black community. (LE+PFS) Medication refusal seen as aggression but in reality the medication side effects are so unpleasant they can't be lived with. (LE) People who don't want to take medication not believed, their own belief and understand not being taken seriously or prioritised. (LE) Medication = big issue! The need for right (anti-psychotic) medication, right person, right need, right time (LE) Medication as a form of control (LE) The actual effects of being medicated (over medicated specifically), being a shell of oneself, looking/feeling like a zombie, carers watching their loved ones in services change (CL) Professionals lack full understanding of spirituality/cultural beliefs when assessing for psychosis and schizophrenia. This can lead to racist practices from professionals around diagnosis and medication management e.g., diagnosis is applied via a Eurocentric diagnostic manual (ICD-10) and antipsychotic medication is predominately 'tested' on the White male population. Black men are mistrustful of anti- psychotic's efficacy (note Rastafarians beliefs around medication contaminating the body, therefore alternative treatment approaches are sought e.g. acupuncture, homeopathy)

10	STIGMA	(LE) What is viewed as stigma of black men (mental health, big black men, aggression) is really a trauma response created by years of racism, and injustice (CL) Stigma (Goffman)and Self Stigma. Stigma power (Pinker) is the commonest form of violence used with a democratic society, and is a form of power and inequality (Tyler). We should consider - How is Whiteness experienced? How is Whiteness embedded in Mental Health Services and its commissioning (this is a form of stigma power). I think commissioners have a key role in providing services that are person led and informed by cultural needs.
11	The LE, PFS and LE+PFS is about where that bullet point came from. 'LE' is the voice of Lived experience and 'PFS' is Professionals. LE+PFS means it came out in both stakeholders findings.	
12	Isaiah + Kenny - THEME ONE including: Identity, Stigma, Spirituality, Racism	
13	Jeremy + Kim - THEME TWO including: Power, Misconception, Injustice	

14	Caroline + Debbie - THEME THREE Mental Health Care and Treatment including: Mental Health, Medication	

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Appendix 6: Two Added Value Examples

Example of Added Value/Impact

1. CONTACT DETAILS

Project title: Improving the Experiences of Black African Caribbean Men Detained Under the Mental Health Act: A Co-Produced Intervention Using the Silences Framework (ImproveAct)

NIHR PRP reference number: NIHR201715

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Please note that the NIHR CCF, or DHSC may approach the individual named above for further information on the Example.

2. TITLE OF THE ADDED VALUE EXAMPLE

Policy and Practice Impact

3. DESCRIPTION OF THE ADDED VALUE EXAMPLE

Policy summary :
The cross-party think tank Policy Connect led a programme of policy engagement as part of the ImproveAct project. This programme has been successful in engaging and informing politicians and other policymakers on the issue of black men's experiences of the Mental Health Act, and the importance of lived experience expertise as necessary for effective reforms – i.e. on the emerging findings of the ImproveAct research.

The key deliverables of the policy engagement programme were:

- 2021 Symposium event
- 2023 Roundtable event
- 2024 Symposium event
- 2024 Policy Briefing Paper
- 2021-2024, private meetings and other engagement with policymakers

These deliverables engaged key figures including:

1. The Minister of State for Care and Mental Health and her team in DHSC
    a. Keynote speaker at 2021 symposium; requested and received event summary paper; her successor has received the Policy Briefing Paper
2. Lord Keith Bradley, a member of the Joint Committee on the Draft Mental Health Bill
    a. Chaired both symposia; private meetings with Policy Connect; requested and received the Policy Briefing Paper to inform his work
3. The Shadow Minister for Women's Health and Mental Health and her team
    a. Keynote speaker at 2024 symposium; requested and received Policy Briefing Paper to inform her work, including her response to the Draft Mental Health Bill.
4. CQC National Mental Health Act Policy Advisor

    a. Participated in roundtable discussion
5. NHS Confederation Mental Health Network Policy Manager
6. NHS England, Deputy Director of Quality Transformation (Mental Health, Learning Disabilities and Autism)
7. President of the Royal College of Psychiatrists
8. NHS Race & Health Observatory Mental Health Working Group, Co-Chair
9. Luciana Berger Chair of the Labour Mental Health Strategy Review
    a. Received a letter from Lord Bradley giving notice of the ImproveAct project; Ms Berger will shortly give the keynote at a Policy Connect event on maternal mental health and she will be invited, then, to review the ImproveAct Policy and Practice Considerations, and to a follow-on meeting on its findings and recommendations with Lord Bradley and Policy Connect experts.

The following summarise the key impacts from this work:

1. **Centring lived experience expertise in policymaking**. A key feature of the policy engagement programme has been the involvement of experts and people with lived experience in all policy events, speaking alongside policymakers and academic researchers. Policymakers are often primarily accustomed to taking in information in forms and forums that exclude people with lived experience – and policymakers' engagement with those with lived experience often takes place outside of a context that affirms those people's expertise. As such, this project had a significant impact in helping policymakers become more accustomed to being informed by the expertise of those who have lived experience of the Mental Health Act.

2. **Developing public policy conclusions and recommendations**. Central to our approach was the recognition that recommendations informed directly from those affected by detention policies are of paramount importance. Drawing upon the insights by the collective expertise of individuals with lived experience, academic researchers, experts and policymakers, we crafted policy recommendations designed to address the current policymaking landscape. By incorporating perspectives from these key stakeholders, we ensured that our recommendations were both comprehensive and impactful. The main recommendation involves the establishment of an independent lived experience commissioning group/council to serve as an consultancy body advice key bodies. For full details of the recommendation and conclusions please refer to the policy briefing document.

3. **Informing key policymaking processes**. Using a multifaceted approach we actively engaged in informing key policymaking processes. One significant avenue was the organisation of a parliamentary roundtable event and two symposia, which served as platforms for bringing together a diverse array of field experts, including healthcare providers, workers, and policy leads. These events facilitated discussions around the project and provided the opportunity to introduce emerging findings and objectives to relevant stakeholders, fostering collaboration and knowledge exchange. Our involvement extended to providing consultation to the Shadow Minister for Mental Health regarding the government's response to the draft Mental Health bill. Leveraging the insights gleaned from the key findings, we offered informed advice to the Minister and her team, highlighting crucial factors that should be considered in the drafting and reforming of mental health policies.

   Furthermore, we actively participated in meetings with individual parliamentarians through the All-Party Parliamentary Group (APPG) for Health, where we advocated for increased awareness and attention to the key policy issue. These interactions allowed us to directly engage with policymakers and highlight the importance of addressing mental health issues within the broader healthcare agenda. Lastly, we contributed to the policymaking process by submitting a consultation response to the Mental Health and Wellbeing plan. This formal submission allowed us to provide targeted feedback and recommendations for inclusion in the development of mental health policies, ensuring that our project's findings and expertise directly influenced the policy reform agenda.

Practice summary

The ImproveAct research team members have actively participated with key stakeholders who have legal duties, roles, and responsibilities under the Mental Health Act. The active and full involvement of people with lived experiences of detention under the Act has been integrated throughout the project. Evidence of successful engagement and impact with different professional organisations are summarised below:

1. Leah, C. Best, D., Thompson, K., and Romeo, L (2024). Blog. *Anti-racist perspectives and the Approved Mental Health Professional role – taking professional responsibility to address racism in practice*. Department of Health and Social Care (DHSC) Chief Social Workers Office in conjunction with the British Association of Social Workers (BASWA). This blog was co-authored by the Chief Social Worker (adults), Dr Lyn Romeo, Dr Caroline Leah (co-investigator) and Debbie Best (carer of a person with lived experience of Mental Health Act detention) and Kenny Thompson (person with lived experiences of Mental Health Act detentions). The blog has a distribution list of over 2k professionals.
2. Dixon, J & Leah, C. (2024). Conference paper. European Sociological Association Conference. '*I don't think there's many Black African Caribbean men that talk positively about mental health services': Mental Health professionals' perspectives on distrust amongst black men detained in psychiatric hospitals.*
3. Leah, C. (2024). Conference paper. *Mental Health Professionals Experiences of Detaining Black Men under the Mental Health Act 1983 – a call for anti-racist assessment practice*. International Academy of Law and Mental Health, Barcelona.
4. Leah, C., King, C., Dyer, J., and Sanyal, N and Thomas, S, Bradon, J. (2023). Presentation. *Improving the Act – antiracist social work practice, lessons from research, presentation on World Social Work Day 2024.* This presentation was delivered nationally to AMHPs, strategic mental health trust leads and mental health social workers at the invitation of the Chief Social Workers Office, DHSC, and BASWA – UK to over 200 professionals, with lead roles under the MHA. The presentation was recorded and is openly available to professionals for ongoing continuous professional development. The channel has 1.38K subscribers.
5. Leah, C., Haines-Delmott, A., and Broderick, I. (2023). Greater Manchester Police Training delivery on *Anti-racist practice and Right Care, Right Person Policy* to contribute to the operational delivery of the policy and police practice across the GMP footprint. Attendees included the GMP Chief Inspector and DCI mental health and EDI leads.
6. Leah, C. Brammer, A., Stone, K., Watson, D., and Vicary, S. (2024) Conference paper. Mental Health Provision in the United Kingdom- Mental Health Policy, Roles and Practice symposium. International Academy of Law and Mental Health, Barcelona.
7. Leah, C. (2023) Conference paper. International Academy of Law and Mental Health, Lyon. A*MHPs experiences of detaining Black men under the Mental Health Act 1983.*
8. Leah, C. (2023). Conference paper. Me*ntal Health Professional's Experiences of Supporting UK Black African-Caribbean Men Detained Under the Mental Health Act 1983*. JSWEC.
9. Leah, C. (2023). ImprovE-ACT Research: Supporting Black and African Men's detention experiences – reflections for AMHP practice. *National AMHP Conference - Research Informed Practice and Practice Informed Research* (online).
10. Leah, C. (2021). Conference paper. Theme: 'People from Racialised Communities'. Improving the Experiences of Black African-Caribbean Men Detained Under the Mental Health Act: A Co-Produced Intervention Using the Silences Framework (ImproveAct). *National AMHP Conference- Research Informed Practice and Practice Informed Research* (online).

4. STAGE OF MATURITY AND NEXT STEPS REQUIRED TO ACHIEVE FULL IMPACT

Further impact will be achieved by:

- Engaging Luciana Berger through the upcoming Policy Connect event on Maternal Mental Health, inviting her to review the briefing paper and organising a follow-on meeting alongside Lord Bradley.
- Participating in the parliamentary launch of the Black Mental Health Manifesto, authored by a coalition of Black-led grassroots organisations, race equity leaders in the mental health sector, individuals, and activists.
- Publishing written a blog piece during Purdah to continue engagement and prepare for a new government after the General Election.

Future practice impact will be achieved by:

- Ongoing working with Policy Connect on the above, continued engagement with the Chief Social Workers Office, DHSC, the AMHPs lead network; BASW, and engaging with the Royal College of Psychiatrists, the Royal College of Nursing, the British Psychological Society, and mental health charities e.g., Rethink, to disseminate the key research findings and practice recommendations.

5. CONTRIBUTION OF THE NATIONAL INSTITUTE OF HEALTH RESEARCH POLICY RESEARCH PROGRAMME (NIHR PRP), DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC) AND OTHER STAKEHOLDERS

DHSC officials were engaged throughout the project, and we benefited from their insight into the department and relevant policymaking processes.

The endorsement from the NIHR added credibility to the project, making people more inclined to engage with this work from policymakers down to lived experience individuals.

Example of Added Value/Impact

1. CONTACT DETAILS

Project title: Improving the Experiences of Black African Caribbean Men Detained Under the Mental Health Act (ImproveAct)

NIHR PRP reference number: NIHR201715

Lead Investigator: Dr Alina Haines-Delmont

Institution: Manchester Metropolitan University

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Please note that the NIHR CCF, or DHSC may approach the individual named above for further information on the Example.

2. TITLE OF THE ADDED VALUE EXAMPLE

Improve-ing Co-production

3. DESCRIPTION OF THE ADDED VALUE EXAMPLE

Summary
Every component in this project was co-produced with health and social care professionals, the police, people with lived detention experience and pillars of the BAC community. The activities and the benefits of the co-production and community engagement that we have orchestrated within the timeframe of this project include:

November 2021 - Systematic Review Workshop
The first systematic review workshop was held to identify search terms and silences that we had missed with the initial searches. Attendees included two people with lived experience, and six researchers. Discussions helped us identify missing searches around spirituality and culture, as this was not coming through in the papers that we had found. This was vital to ensuring that the final papers were of utmost relevance to BAC men who had experienced detention under mental health legislation.

September 2022 - Writing retreat
Two people with lived experience, and four people from the MMU team took part in a writing retreat at Gladstone's Library in Hawarden, Flintshire. The aim of the retreat was to understand the main themes within the included review papers and to discuss the silences, issues/experiences omitted within the literature, that BAC men going through the detention process experienced. This helped to build trust between the team members and people with lived experience and allowed for an open and honest dialogue.

May 2023 – Mental Health Community Celebration Event
This event aimed to build a relationship and rapport within Manchester's BAC community and ignite discussion on what needs to change about mental health services and how they can better serve marginalised communities. The event included presentations on ImproveAct's emerging findings, a Q&A panel with people with lived experience, a live band, and Caribbean food. Attendees included people with lived experience, professionals, researchers, and third sector workers.

Discussions highlighted that pillar of the community (e.g. faith leaders, business owners, and elders) are providing informal mental health support because of the compassion they have for their community. They are the go-to people because they are trusted, independent, and well known in these communities. This support has become a lifeline to many vulnerable community members but is overwhelming those delivering it. Policy that focuses on funding initiatives facilitated by and for the community, that are already established and trusted will ensure these initiatives can continue to support those most vulnerable and aid the prevention of mental health crisis.

These community pillars often have the same distrust of services and have experienced researchers and professionals treating them as data or research to be researched on rather than with. Collaboration must be meaningful, patient, authentic and honest. This means allowing time within research for engagement, addressing historic harm, and learning about who the people are not just what they offer or how they can be of benefit to professionals. Formal training like mental health first aid can empower the individual and putt the power back in their hands by giving them to tools to support those in their community. Future funding commissioners should consider skills-based training (e.g., mental health first aid) as an addition and/or alternative to PPI payments.

October 2023 – Lived experience community creative workshop
This workshop was for BAC men and BAC carers with lived experience of mental health detention. Attendees (n=30) included people with lived experience, carers, community pillars and researchers. A key finding was healing through creativity and community. We collaborated with a Black carer and business owner in central Manchester who had previous experience facilitating creative workshops. Their status with the community was key to the workshop's success. It demonstrated for the community to engage with research we had to first in engage with them. This meant embedding ourselves in their culture; food, music, attending their events, supporting their businesses, hearing their stories and experiences, to build a meaningful long-lasting connection.

Workshops like this could also lend to initiatives focusing on prevention rather than cure, as people have a space where they can explore their experiences and build a community of people that they can both support and feel supported by. The picture below is a red and black striped mask created by one of the participants, he explained that he had spent most of the day feeling angry because of work, and that attending the workshop helped him recognise that was how he was feeling and why. Oftentimes, a mental health crisis can be triggered by an amalgamation of smaller, everyday experiences and, using the example of the participant mentioned, having a space to explore those experiences and be supported and affirmed by a community could prevent a crisis.

A picture of some of the masks created at the workshop.

November 2023 – Lived experience community showcase event and focus group
This event was a showcase of the poetry and art created during the October workshop. Attendees (n=10) included people with lived experience, professionals, researchers, community pillars and third sector workers. Its aim was to facilitate deeper discussions of people's mental health services and share knowledge as people with lived experience, researchers, and professionals working in services.

A major point of contention highlighted was medication. There was a shared experience among carers and those who have been in services of medication dulling or flattening their personality and what made them human, healthcare staff changing dosages without understanding how this might affect the individual, and, most concerningly, not wanting to make a formal complaint for fear of how it might negatively impact their/their loved one's care. Attendees discussed the quality of the medication prescribed to them and the debilitating side effects that accompany them, doctors then treat side effects with more medication. This ultimately shows a lack of investment in the health of patients and a culture medicating people instead of taking the time to treat issues at the source.

Classism and the differences in the quality of care and treatment received by the working class and the wealthy or those with greater access was also a reminder to us as researchers that race does not exist in a vacuum. Renumerating experts by experience has been a key aspect of the success we have had with these events, as ensuring that people are paid of their time, expertise, and vulnerability to bridge the socio-economic gap across race is essential. What can't be ignored is that staying well has become a privilege, and many BAC people aren't able to invest in their wellbeing whether that is through talking therapy, taking time off work, or private healthcare for example. This means they must rely on the NHS' care, which is unfortunately underfunded, overworked, and understaffed. A person centred, trauma informed practise cannot be embedded into services without more staff to relieve the current pressures, healthcare staff can't divest from the culture of medication as the sole form of treatment without more counselling services and access to alternative, holistic treatments. To improve the experiences of services and reduce detention rates in the long term, it is vital that the issues within the NHS are remedied drastically and meaningfully.

4. STAGE OF MATURITY AND NEXT STEPS REQUIRED TO ACHIEVE FULL IMPACT

The Systematic Review is currently under review for publication in PLOS Mental Health. This is the first review of its kind to have been co-produced and co-written by people with lived experience, and to challenge the silences in psychiatry and mental health services. The information from this review has already fed into our key recommendations for the Mental Health Act. Policy Connect and our work with the Mental Elf will help us to keep pushing for this.

Our work with the community has led to some amazing contacts and we are already the first University to sign up to the Black Mental Health Manifesto. DB, a BAC carer and member of our team also helped to put the manifesto into production.

The ImproveAct conference on the 21st May 2024 will bring together the work we have done across this and the policy strand. We will continue to publicise our recommendations through further publications as outlined in the main report.

5. CONTRIBUTION OF THE NATIONAL INSTITUTE OF HEALTH RESEARCH POLICY RESEARCH PROGRAMME (NIHR PRP), DEPARTMENT OF HEALTH AND SOCIAL CARE (DHSC) AND OTHER STAKEHOLDERS

N/A

Appendix 7 – Systematic Review Publication

A Co-Produced Review of the Experiences of Black male detention under mental health legislation: Challenging discrimination in Psychiatry using the Silences Framework.

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Abstract

The number of detentions under mental health legislation is growing, disproportionately impacting on Black men. Previous research into the over-detention in mental health services of Black people is repetitive and solutions to reduce disparities are either ineffective, not enacted, or outdated. This unique and innovative systematic review, using the Silences Framework, analyses national and international literature and draws on the views of people with lived experience to flip the narrative and support change for Black men compulsorily detained in mental health settings. The systematic review was robustly conducted through searching three databases: EBSCO, ProQuest, and PMC. The search terms included one of three identifying features: ethnicity: Black African Caribbean; gender: male; and detention: detained under mental health legislation. Searches were conducted in September 2021 and February 2024 and included papers from 2000 to 2024. The review was conducted using the NIHR systematic review protocol. It was registered with Prospero CRD42022274045 and has been reported using PRISMA guidelines. The searches resulted in 15,300 papers being identified, which were reduced to 34 papers for inclusion. A qualitative thematic appraisal was conducted on the included papers. Throughout the systematic review process, people with lived experience on the review team explored the Silences that were not present in the

literature and co-developed the key findings and recommendations. Three broad themes were developed taking into account what was being said in the literature and what was not (silences): (1) contextual identity; (2) culture, spirituality, and religion; and (3) power, language, and communication. People with lived experience discussed what these themes meant to them and the results are presented as 'Screaming Silences' - a concept that amplifies what is known (by patients, family and friends, professionals, and others), but is not explicitly discussed within the literature. We show that academic understanding of the detrimental treatment and care of Black men has barely changed in over twenty years. This review is original and novel in using a lived experience lens within the Silences framework to interpret and validate review findings and make actionable recommendations to enable change, reduce Black men's detention rates and improve experiences. The recommendations centre on: patient involvement and clear communication; reducing disparities through anti-discriminatory policies and practice; the promotion of cultural competence; community campaigns, collaboration, and support for carers; monitoring and auditing; and improving future research through co-production.

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Key words: Co-production; lived-experience; mental health services; community

The authors declare no competing interests.

Introduction

Black male experiences of mental health detention throughout the world are subject to bias, discrimination, and mistreatment[1]. This research presents arguments from thirty-four high-quality papers, incorporating some of the most important research in this field from over two decades. Through introducing the Silences Framework to our systematic review methodology, we are presenting a novel and world-leading approach to tackling racism within psychiatric services using the voice of lived experience. The research reviewed in this paper highlights that changes to services in the Global North are not yet being made in a substantial enough way to prevent discrimination. Giving a voice to those who have not had one in this sphere is vital to understanding how to change services for the better. Although this research was conducted in England, we suggest solutions to policy and practice that can be incorporated into the new Mental Health Act (1983)[2], and world-wide.

Mental health services are in crisis. Data in England and Wales alone has shown a 20 per cent increase in patient detentions over recent years (2014- 2016)[3], prompting reviews of the Mental Health Act (MHA)[2,4] in England and Wales [5,6], and the Government's Draft Mental Health Bill[7]. Of particular concern was the over-representation of Black African Caribbean people under the MHA, an ethnicity marker defined by the UK National Health Service (NHS)[11] . The experience of Black men was viewed as particularly concerning, with the perception of them as "big, Black and dangerous" being a major worry for people with lived experience[8,9]. Black African Caribbean men are more likely to encounter the mental health system via the criminal justice route than their White counterparts[6,10], this has led to calls for initiatives to reduce the use of section 136 which gives police the power to take people to a place of safety for a mental health assessment. The most recent figures show that 65.3 per

100,000 of Black people were detained under section 136 compared to 29.1 per 100,000 of White people[11,12].

However, data shows over double the amount of Black people with mental ill health die in custody than any other demographic[13]. Studies have compared differences in the rates of detention across ethnicity by examining data showing that Black people are more likely to be detained for assessment or treatment under the MHA. Statistics in England from 2020-2021 show that this has steadily increased over the years with 343.5 per 100,000 Black people detained under the MHA in this year, in comparison to the reducing 74.7 per 100,000 of White people[14]. At over four times the rate of detention, it is clear that racial disparity is not being challenged effectively in mental health services[12].

The need to understand what is happening during mental health detention for Black men requires creative methodologies, as previous research in this area is not being used to direct practice or policy. The Silences Framework[15] was developed for marginalised groups to be able to speak their truth about their experiences within healthcare. Through the framework we can challenge what is 'known' (by conducting a systematic review) by finding out what is actually happening to Black men (including people with lived experience as co-producers of the research) within a lived experience epistemological and methodological model that is on par with other clinical frameworks[16,17]. Most notably, a recent paper by Solanki et al.[18] conducted semi-structured interviews with twelve Black ethnic inpatients. Solanki et al.'s[18] findings mirror that of the Silences discussed in relation to our systematic review and showcase how listening to the person with lived experience brings a depth of understanding that outweighs any longitudinal quantitative studies. This research demonstrates that qualitative data, which is sometimes considered less valuable, can be of higher quality when it includes the perspectives of those experiencing the issue. In this study, the Silences Framework gives a voice to Black men who have been detained under mental health legislation, and their parents and carers.

Despite the wealth of research into racial differences in involuntary detention rates, the same conclusions are being made by much of that research but the narrative of the racialised lived experience is yet to be seen. As has been recommended in many of these studies and perfectly articulated by The Sainsbury Centre for Mental Health (p 12)[19] "an important first step to improved service provision is engaging with service users". This paper does exactly that through co-production using the Silences Framework, and we urge practitioners and academics globally to do the same. While there are reviews capturing evidence with regards to experiences of detention under mental health legislation, to our knowledge this systematic review is the only one that includes people with lived experience as co-producers of the research.

The research question asked: what are the experiences of Black African Caribbean men who have been detained under mental health legislation? The objectives were twofold; initially to explore in what context does detention under mental health legislation occur for Black African Caribbean men; then to identify whose voices are missing from the evidence and what questions remain unanswered through the Silences Framework.

Methods

Co-producing a systematic review including people with lived experience is a novel approach, and there is currently no framework that determines how this is conducted or written for publication. Therefore, we have written openly about the way our research was conducted and have included as much explanation as possible in the hope that moving

forward, a framework for co-producing research may be designed. The authors epistemological stance for this study was a form of critical realism[20]. The systematic review was conducted with a realist subjective lens which interprets the findings via real-life experiences through the Silences Framework[15]. As there were experts by experience in the research team it was important to the authors that the main themes in the systematic review were explored through structured discussions focusing on the impact of the people who had been through these life experiences. All of the authors values were therefore considered in the reading of the data and space was given for each researcher to be reflexive as they read through the articles. Although the analysis was deductive, the Silences Framework allowed for an inductive approach which was experiential rather than based on the knowledge of the existing research. Critical realism takes into account systems and social structures which was important to the research team when analysing the findings from the systematic review. This required the team to use a thematic approach to the analysis rather than focusing on the quantitative data. The findings centre on the qualitative evidence, despite the majority of the included papers having a quantitative focus.

Studies were initially included if they were published from 1983 to 2022, published in English and including a specification of ethnicity (using Boolean terms) where Black, mixed heritage, African, or Caribbean is stated OR specifying the gender as male, OR specifying detention. This was to ensure all possible literature was captured, and we would limit this at the full paper stage, ensuring the papers had Black (or any associated words), male, and detention under mental health legislation, stated within their study. Exclusion criteria included papers not in English, and did not specify ethnicity, was about females only, did not include detention, and where participants were under 18 years old. The systematic review was registered with Prospero (CRD42022274045).

An iterative 5-step search strategy was adopted to identify studies:

an online search for systematic reviews,

grey literature search;

search appropriate journals;

reference lists from systematic reviews and meta-analyses checked for additional relevant studies;

Workshops enlisting advice from stakeholders including Black African Caribbean men who have experience of being detained, other professionals, lay people and experts as required.

Initial searches were decided upon in conjunction with librarians from the NHS and UK Police and the results were imported into Covidence[21]. Appendix 1 shows the search strings used. An updated search was conducted using the same databases and search strings in February 2024.

After duplications were removed, a total of 15,300 papers were found which were uploaded into the management tool Covidence. Covidence was set-up so that each paper had to be reviewed by two people, with a third person reviewing any conflicts. Pragmatically and due to the time/ person power constraints of the research we needed to reduce the numbers of papers, so the initial search criteria were reduced to exclude research within criminal justice and papers published after 2000. The total reduced to 636 papers after the title and abstract screening and by removing papers using the additional exclusion criteria. A further search was conducted after a workshop with experts by experience in November 2021. These

added the words spiritual, religion, psychophobia and a further 42 papers. After the full paper review, 72 papers matched the streamlined inclusion criteria.

[Figure 1]

We used the Mixed Methods Appraisal Tool MMAT[22] to conduct a quality assessment at this point. Papers that scored low (bias) across all seven questions by two reviewers were included in the final study (a score of 7 indicated acceptance). A further search was conducted in February 2024 to capture any studies that had been published since 2022. This resulted in two more papers. The final 34 papers are summarised in Table 1.

[Table 1]

Two reviewers conducted an equality appraisal based on a previous version by Bhui et al.[23], providing a score on how each included paper describes ethnicity, gender, and detention (appendix 2). This equality appraisal showcased the differences in the explanations of these demographics and therefore the difficulties involved in comparing the data. As this is not an approved measurement tool, we did not use it to exclude papers, but felt it was an important to include how vastly different demographics are recorded in healthcare, and how difficult that makes it for researchers to use the data to state anything with any certainty about equality, diversity, and inclusion issues. Systematic reviews were given a rating of N/A (not applicable) as the data was too varied.

The Silences Framework[15] was used as an overarching framework for the whole review. We used 4 stages of the Silences Framework to gain an understanding of what silences currently exist for Black men who have been detained under Mental Health legislation. Stage 1: Working in silences: a systematic literature review to provide a base from which we begin to draw out what is unknown or unsaid about race, ethnicity, and compulsory detention. Stage 2: Hearing silences: reflexive spaces dedicated to listening and hearing individual experiences. Stage 3: Voicing the silences: the analysis of the findings was continuous and cyclical. Initial findings were presented with attendees afforded the opportunity to give feedback. Stage 4: Working with 'silences': Researchers reflect on the potential impact of the findings, and what steps can be taken to achieve the goal or aim of the project.

The four stages are cyclical, and each stage is to be considered several times as necessary throughout the life of the research. Through adopting a Silences Framework[15] and a truly authentic empowerment model of co-producing the research with people with lived experience, (Black people who have been detained under mental health legislation or caring for somebody who is, or has been detained), and mental health professional in these spaces, we collectively and continually questioned what was missing from the research. This authenticity was based on the racialised lived experience that was embedded this into the research from pre-production to co-production.

During this systematic review, three people with lived experience participated in conducting the review and co-developing the findings. Some of the references to their words are left intentionally ambiguous as we have an ethical responsibility to protect our colleagues and co-authors. The silences explored in this paper are the three most prolific themes arranged from a list of 50 subthemes. This was agreed in collaboration with all of the authors. Of the three people with lived experience on the team, one was a Black man with experience of mental health detention and two of those people have been carer to a Black man who had been detained. Other members of the research team also had lived experience, had worked as mental health professionals, or both. More people with lived experience contributing to this systematic review could have generated richer feedback from multiple perspectives, and possibly different silences.

We held a total of four workshops in various guises. The first workshop was in November 2021, to build a coding framework utilising the papers from the full paper search. Six main themes were created from this initial review: ‘Variations in Pathways’, ‘Details Surrounding Detention’, ‘Misdiagnosis’, ‘Sub-demographics within Blackness’, ‘Poverty and Social Influences’, and ‘Legislation’. During the workshop, it was agreed that the themes portrayed a realistic view of what it was like for Black men who had been detained under mental health legislation, however, what was said did not go ‘far enough’. This meant that although interesting points are raised within the literature, the people with lived experience felt that the researchers were too cautious with their interpretations, or did not include enough voices of the participants.

Research silences identified by lived experience co-researchers included religion and how empowering spirituality has been for some, the role of the police in detention, and the healing that takes place outside of services and often by oneself. This led to a second literature search to specifically find literature that included the search terms: ‘psychophobia’, ‘spiritual awakenings’ ‘alternative spirituality’ ‘mental health advocacy’ and ‘mistrust’. After going through the search process again, including quality review, one more paper was added to the final literature.

After collaboratively conducting a full review of the literature, a second and third workshop were held in April 2022 to produce the final themes of the paper. Analysis of the papers was through thematic analysis[24], and was conducted through hybrid (online and in-person) workshops. Two people read each paper and extracted the main findings. Flexibility of thematic analysis allows for the generation of themes across various methods of research and across multiple positionalities and theoretical epistemologies. The team read through a portion of the papers each before coming together to discuss the data extraction. This took place in the form of collating themes from each paper and determining which were the ones that came up the most. The second workshop involved the whole research team and produced 50 subthemes with four potential overarching themes and Silences found in the literature. The third workshop included two researchers and two people with lived experience from the review team. The people with lived experience lead on reducing the 4 overarching themes to three, alongside articulating the corresponding Silences. The initial themes and subthemes are presented in appendix 3.

The first draft of the review was created in September 2022 at a two-day writing retreat and included six members of the research team, two of which were people with lived experience. The writing retreat was created specifically to allow for undivided space and time to work on the first draft in a supportive, informal way as some of the researchers did not have as much experience as others in writing up a systematic literature review. This reduced any inequality felt within the team. During the retreat we also drew on the expertise of the Silences Framework method from its creator[15].

On day one we familiarised ourselves with the themes created from the literature review and discussed the initial silences. On day two Professor Laura Serrant, the creator of the Silences Framework, led discussions about finding the silences within the literature. Before the end of the second day, we had created the initial structure, themes, and silences for the systematic review paper. Versions of the paper were then created collaboratively through multiple online and in-person meetings, phone calls, and emails.

Researchers have a moral and professional responsibility to avoid harm to all study participants in any study. For experts by experience to feel comfortable about voicing silences, we adopted a reflexive approach where potential sources of sensitivity were understood, identified and the potential impact considered and proactively planned for as

part of the study design. Distressing topics that emerged during the formulation of the systematic review led to people with lived experience needing time away from the project and mental health support from the qualified counsellor on the team. While a counsellor was available to all those involved in the project, more robust mental health support could have been developed in collaboration with people with lived experience prior to the start of the project.

Results

Most of the papers (n=23) were based on studies conducted in the UK, mainly in England, however many of the studies included Wales and some included Scotland and Northern Ireland. Five studies were conducted in the USA, two in Canada and one in Portugal. Three systematic reviews used studies from multiple countries, with another two systematic reviews including papers from the UK only. There were 21 quantitative studies, five systematic reviews, five qualitative studies, two case study designs, and 1 meta-ethnography. Whilst the exploration of experiences predominately requires a qualitative answer, we have synthesised the quantitative and qualitative data to provide a more holistic overview. Quantitative data was thematised by using the subheadings to the data commentary, much in the same way that qualitative data uses subheadings to describe themes.

A final writing workshop was held to address all of the themes identified from the systematic review, and identify the silences within them. The final themes were: Contextual identity; Culture, spirituality, and religion; and Power, language, and communication. These have been presented as a discussion of the systematic review findings, before voicing the silences relating to those points. This approach helps illuminate what is not being said in current research. The themes presented below is therefore structured beginning with information from the existing literature, as analysed by the full team, followed by a discussion of the silences that people with lived experience felt was missing.

Contextual identity

Within health services, the demographics used to describe patients are not individualised, but grouped into crude factors that only help to identify trends. This grouping together of data means that identities can be seen as monolithic, or as “one size fits all”. This can be problematic in mental health services as there are many interrelated factors present in people’s lives that could mean that misdiagnosis occurs, as a diagnosis could be based on the presenting factors alone. Black men in mental health services seem to have exactly this issue, and the included papers explore how their identity is described in relation to detention, specifically compulsory detention under mental health legislation across the Global North.

The included literature reports that Black men are more often detained through compulsory or involuntarily detention under mental health legislation than patients from other demographics[1,10,26,27,28,29,30,33], and the method of detention is likely to be through contact with the criminal justice system [1,10,26,27,28,29,30,31,32,33,35,35,51]. Black men who have been detained are usually younger than their White counterparts, are from socially deprived and minority-dense areas, are unemployed, have reached lower educational attainment, are single, live alone or in supported accommodation, and are more likely to be in insecure housing or are homeless[1,27,29,31,33,35,36,37,38,39,40,41,42,43,44].

Black men within these studies were also less likely to have a general practitioner (GP), have regular medical check-ups, and were more likely to mistrust healthcare professionals[1,10,26,28,33], despite having longer symptom durations before being detained[32,38,41]. Where a GP (or equivalent) was seen regularly, there were lower rates of

compulsory detention[38,41,42]. This highlights that there are deep-seated systemic issues when it comes to accessing help and support in all areas of healthcare services for Black men.

Ethnicity was not found to be a statistically significant part of detention, or worse experiences of detention, in several studies[1,39,41,43,45]. Barnett et al.,[1] posit that the studies in their systematic review found that there is a lack of primary evidence for much of the reasons given behind racial disparities. Singh et al.[46] believed that the higher detention rates could be due to the distribution of ethnic groups around the sites that their study was conducted within rather than other factors previously thought to be problematic, and Raleigh et al.'s[39] and Rotenberg et al.'s[41] studies both found no statistically significant evidence that there was an association with diagnosis or worse experiences of psychiatric care. Potential explanations, however, seem to coincide greatly with the identities of Black men as identified in the 34 included studies. Barnett et al.[1] for example states that increased rates of detention for all patients included factors such as the increased prevalence of psychosis, perceived risk of violence, increased police contact, absence of or mistrust of general practitioners, and ethnic disadvantages. Similarly, Singh et al.[45] describe factors related to compulsory detention including a diagnosis of a serious mental illness, presence of risk, living in supported accommodation, and living in London. These observations, whilst not being statistically significant in these studies are commensurate with a multitude of research studies, many of which are included in this analysis.

Bansal et al.[54] terms having a mental illness as a 'form of social death' (p21). This highlights a further struggle for Black males being detained, as they feel as though they may be shunned by their community. Fear of being stigmatised in their community is a pressing issue for people with mental ill health. Solanki et al.[18] also described how some participants felt that their family and community stigmatized mental illness. The perceived lack of support outside of detention is problematic as the risk of being reintegrated into the community with an identity changed through a mental health diagnosis may be almost as fear inducing as being taken into mental health detention initially.

This review highlights the enduring disparities that exist within mental and general health services for Black men dealing with mental ill health. The research shows that identity is complex and multi-faceted. This means that although statistical significance may not support the difficulties that Black men face, what we need to understand is that the relationship between the contextual factors of compulsory detention and being a Black man is clearly shown[1,49,29,27,28,30,38,45,34,44.] Intersectional identities need to be understood to address the holistic issues experienced by Black men. It must be assumed that the individual may have experienced all these contextual factors, or none of them, with a wide spectrum of experiences in between[10,46,26,42,18]. Many of the included papers support the view that people should be treated as individuals and support should be tailored to their needs based on an understanding of culture, societal, and health needs[31,32,1,10,51,35,50,26,33,39,48,25,54,18.]

Identification of silences within Contextual Identity

A number of silences were identified around contextual identity, centering on the view that Black people are grouped as one and assumed to have the same or similar identity to one another. Currently, the literature reports on Black people's experiences only through the lens of their Blackness, a reductionist approach that fails to recognise the complexities of their self-identity; as such, biases against gender, sexuality, and class are not explored in tandem with race in much detail or beyond statistics. This does not adequately explore intracommunal differences among Black people. Some of the included studies documented the correlation between poverty and detention rates, and differences in detention rates among men and women, but no papers spoke to whether the negative experiences of Black

men are exacerbated or multiplied by other identities such as being queer, or from a working-class background, for example. Seeking to understand the racialised experience in a vacuum can contribute to a cycle of silencing by not considering the narratives of those who have multiple marginalised identities. Person-centred care must seek to understand and care for the whole person beyond their race, allowing for a nuanced understanding of gender, sexuality, and class. In an example provided by an expert by experience, they explain that not only are they Black, but they are also a product of their upbringing, their sexuality, and much more. Those identities matter. They not only shape one's behaviour and perspective, but they will also shape the behaviour and perspective of those who provide mental health care, similar to the ways Blackness can be perceived in services.

Culture, spirituality and religion

Only six papers[22,25,46,47,48, 54] explicitly explore the role of culture, religion and spirituality in Black people's experiences of mental health services, however these topics featured heavily in the discussions of the authors. The authors believe these factors can be misinterpreted and misunderstood which can lead to diagnostic errors and diminish the importance of spirituality within healing.

Clinical terminology was found to medicalize the view of spiritual practice by patients within psychiatric services[25,54]. The healthcare practitioners framed the experiences of patients as a part of their mental health diagnosis and posited this as evidence of poor insight and judgment. These 'features' were included in patients' notes and recorded as factual information. The notes omitted to record any personal or cultural information for context. An alternative discourse offered in Kaselionyte and Gumley[25] review found that first person accounts and interpretations of spiritual experiences were accepted and supported through listening, the use of spiritual guides or teachers and grounding techniques to promote self-healing.

Bhui et al.'s[23] study of therapeutic interventions to improve communications between Black and minoritised patients and professionals in psychiatric services found that effective interventions considered personal stories, cultural adaptions, and empowerment. Valenti et al.[47] found that patients appreciated it when their cultural norms and religious beliefs were respected during their hospitalisation.

Whaley's[48] study of paranoia in Black African-American patients found that there is a difference between the mistrust that the patient has culturally and interpersonally, and this is difficult to determine in the psychiatric setting. Interpersonal mistrust may be presented as fear of what White clinicians may represent to them in the wider social environment, which could be detrimental if the individual has experienced racism or prejudice. Cultural mistrust could be alleviated by having a clinician with a shared cultural perspective as the patient may feel more relaxed knowing that there is a shared understanding. Whaley[48] stated that it should be expected that Black patients raise complaints about White clinicians, but that these should be fully explored rather than dismissed as part of paranoia, delusion, or a sign of mental illness. The study found that there was no reason to associate cultural mistrust with a higher level of violence, as had been previously indicated by studies.

Services that do not utilise spiritual or religious practice as part of the healing process could be making issues worse for the patient and enhance the trauma of being detained[54]. Bansal et al.'s study found that by not considering people holistically and adhering to a social model of mental illness in addition to the medical model, mental health services are contributing to epistemic injustice, oppression, and discrimination[54]. This study also highlights that Black and minoritised mental health staff do not feel empowered to speak up or intervene on

behalf of the patient when it comes to culture, spirituality and religion[54]. The authors state that the evidence from the meta-ethnography indicates the answer to the issue may not therefore lie in recruiting a more diverse workforce[54]. However, it could alternatively be interpreted as valuing the experiences of a diverse workforce is therefore vital, and staff should be encouraged to share their knowledge in a supportive environment. Instead of assuming that a more diverse workforce is not the answer, it may be that targeted recruitment in more leadership positions may enable Black and minoritised staff to feel more empowered.

All mental health professionals should receive training in cultural competence to better understand and address the unique needs and preferences of patients from diverse ethnic backgrounds[44]. This training should focus on improving communication and addressing potential cultural barriers. Improving mental health care for Black men involves culturally adapting interventions, prioritizing patient-centered communication, and conducting economic evaluations to support evidence-based policies and practices[23]. This includes utilising a wide range of knowledge systems within evidence-based medicine to accommodate various understandings of spirituality and acknowledging the co-existence of different perspectives by incorporating them into clinical practice and research[25]. Understanding of mental health within family members and the community could also reduce stigma and fear[20]. Gaining input from community leaders, advocates, and individuals with lived experience, can help to tailor services to the unique needs of Black men and address cultural and language barriers[10].

Identification of silences within culture, spirituality and religion

Voicing the silences when reflecting on matters of culture, spirituality, and religion, was very personal for the experienced members of the research team. On the whole, this topic was left out of academic and clinical studies. It was believed by the people with lived experience that the topic was normally deemed too sensitive and difficult to address within the academic literature, yet it was the most important issue for them.

Those with lived experience on the project explained that spiritual practices and beliefs that exist outside of Judeo-Christian religions are often misunderstood and pathologized in mental health services. Behaviour or beliefs that do not align with Western concepts of spirituality become a part of the individual's mental health diagnosis or evidence of a mental illness, which strips them of their autonomy by attributing a choice and a belief that could ground them to their mental state. Similar to findings reported by Kaselionyte and Gumley[25], we acknowledge that some behaviours or beliefs can be harmful. However, the belief that there is only one truth that is essentially decided by the practitioner, continues a cycle of silencing that pathologises beliefs that could be an essential part of the individual's recovery or a barrier against institutional racism.

Another overarching silence that resonated among the authors was the idea of professional curiosity; the desire to remain open and curious about who the patient is as a human being, their life history and how that contributes to their current behaviour and mental state. It is essential that those responsible for formal diagnosis have a willingness to understand traditions and cultural differences. It is equally important that all professionals are trauma informed and work from a place of curiosity, encouraging practise that aids recovery and helps ensure that individuals' thoughts or emotions are not medicalised and or inappropriately attributed to mental health.

The perception that Black people all share the same views and experiences of mental health services contributes to the misunderstanding of their experiences. This contributes to a cycle

of silencing experiences that do not align with more accepted or well-known experiences and leads to reductionist models that silence and disempower the racialised lived experience in research, mental health policy and practice. Though there is a collective solidarity among Black communities in the UK, there is also intra-communal segregation between African and Caribbean communities, even some division within African and Caribbean communities based on country, island, and religion. The findings gathered from the literature and the silences identify the importance of culturally appropriate care that is malleable, open to change, and does not assume the cultural needs of a patient just based on their race or background.

Power, language and communication

Fear is often at the centre of the distrust experienced by Black patients, this could be fear based on experiences of racism, fear of the stigma attached to being diagnosed with a mental illness, and the fear one might experience when entering mental health services[49]. Most notably, participants in one study attributed some of their fears of mental health services to the ways services mirror other oppressive institutions such as education systems, the police, and the criminal justice system[50]. The oppression felt by participants in their everyday lives was believed to be replicated in mental health services, with many participants expressing fatigue in fighting against racism**.*. In Whaley's[48] study scoring high on a cultural mistrust scale was positively correlated with a mistrust of mental health services even if they also believed that White doctors were better trained than doctors of colour, highlighting the importance of patients' trust in staff and services. Racial disparities in detention and diagnoses are evident throughout the included literature reporting that Black men are more likely to be compulsorily detained under mental health legislation[26,29,36,37,39,43,45], they are more likely to be admitted by the police or criminal justice system, they are most likely to be diagnosed with schizophrenia, schizo-affective disorders or psychosis[1,31,35,27,32,38], they spend longer in detention on average[33,40], and are more frequently re-admitted[1,38].

The included literature reveals serious racial disparities in psychiatric care around the Global North. Bias, whether conscious or unconscious, is affecting the lives of Black men and means that psychiatric services are not considering either cultural or racial factors when interpreting symptoms or implementing care plans[32]. As a result, there is a mistrust of the healthcare system, which often leads to delayed presentations at emergency or crisis settings instead of getting the care they need at the right time[28,45,49,51]. Many of the studies reported people feeling as though they were being coerced or treated differently due to their race, and this made it difficult to feel safe and trust the care they were being given[50,52]. Psychiatrists also stated in one study that they found it difficult to talk about race and culture highlighting the need for training[49]. Boydell et al.'s[46] study found that although patients did not agree with their medication and other aspects of care, their satisfaction levels with psychiatric service were the same as White people. Similarly, Raleigh's study did not support the view that Black people were treated worse in psychiatric care, and two systematic reviews stated that although racial stereotyping, alienation, mistrust of services, greater stigma, language barriers and poorer detection of mental illness were cited as factors relating to worse treatment, there was often no real evidence supporting this[1,45]. One study found that discriminatory behaviour of staff was not just by White people, but some participants also experienced negative treatment by Black and minoritised staff.

Communication from healthcare staff to patients was found to be coercive and oppressive, often using inaccessible language (medicalised 'jargon') which was perceived as power play. Black participants in a study by Chakraborty et al.[50] question their diagnosis, with one

participant stating they have depression and not the schizophrenia that they have been diagnosed with, and another explaining their mental illness is a manifestation of physical pain. Providing some positive experiences for community treatment order (CTO) case managers, participants in a study by Mfoafo-M'Carthy[52] reported that having a good rapport with their case manager or having a worker who was understanding and supportive helped them feel less like a patient and allowed them to communicate freely. However, most of the patients in this study reported being treated negatively as a result of agreeing to be put on a CTO. They state that they had been coerced into agreement whilst not fully understanding the circumstances[52]. Many patients felt as though they lacked control over their treatment decisions, although this was dependent on the level of respect they got from the staff in the hospital[45], and Solanki et al.'s study found that the lack of choices patients were given, resulted in them feeling a lack of support in the way that they wanted it. In Valenti et al.'s[47] study, patients reported abuse and behaviours from staff that negatively impacted on their experience.

Identification of silences within power, language and communication

People with lived experience noted two silences regarding language and communication in services; the quality of language (whether language was appropriate or used to confuse and control), and communication used by staff and services, and the lack of curiosity from staff to understand the language and ways communication used by patients. It was also recognised that qualitative, in-depth studies reporting the perspective of both people with lived experience and professionals is scarce within the literature.

The language and ways of communicating used by services and professionals can be silencing for carers and patients and create confusion and conflict. People with lived experience reflecting on their experiences with services, recalled gaslighting language, staff and doctors that making them feel inferior and their concerns being ignored. One's environment and the way they are treated can tie heavily to their identity, the oppressive language used in services can chip away at someone's identity and what makes them who they are.

Language and behaviour are open to interpretation and there are often deeper meanings within words, language and communication. Without curiosity and trauma-informed systemic practice the deeper meaning behind the behaviour of patients can be lost, limiting the chance of a true rapport, or understanding between patient and worker, and hindering healing for the patient. People in services choosing to keep their head down or following rules they do not agree with can create a revolving door, where people leave services without their mental health needs actually being addressed, and equally, reacting aggressively out of fear or frustration will prolong their stay in services. When it feels like those are the only options available to you, the healing and recovery of the person cannot happen. Services would better treat people and reduce readmission rates if they fostered an environment where people felt safe and comfortable to express how they feel, both the good and bad. Staff members could be more engaged, empathetic, and curious, dedicated to empowering the patient, helping to address the hierarchical power balance between them.

Discussion

Experiences of Black men who are detained under mental health legislation have not changed in meaningful ways for at least the past twenty years. This systematic literature review shows how research papers report the same issues repeatedly: Black men are younger, usually diagnosed with psychosis, have longer hospital stays, are more frequently readmitted, are unhappy with their treatment, and are more often detained through the

criminal justice system than any other demographic. Their voices are missing from literature until now, and our unique Silences Framework systematic review has allowed for people with lived experience to voice their unheard experiences. The statistics show that the over-representation of Black men in mental health detention comes at a human and financial cost, demanding attention[19]. Our findings add further meaning to this. Presenting the findings from the existing literature alongside the voices of those with lived experience is a way of changing the narrative and exposing the silences[15,17].

Black men are presented within the literature as one collective community with similar beliefs, values, and social capital[1,23,27,29,46,33,35,36,37,38,39,40,41,42,43,44]. The silences that were discussed by people with lived experience showed that being 'treated as a monolith' meant that individual identities were ignored. By ignoring the intersectionalities that exist for Black men, there is a chance that misdiagnosis and mistreatment may occur, which is where racism, difficulties with staff and understanding the treatment given; and a lack of choice for treatment and support continues to be perpetuated[18,32,47,50,52,54].

The primary concern raised by many Black men in the literature and from people with lived experience, is about their specific experiences of *racial discrimination*. However, there is a need to also emphasise the importance of intersectionality while acknowledging that race-specific issues remain a crucial part of the narrative. It is critical to clarify that Black men are most likely to be detained and suffer biases due to their Blackness; highlighting race as a primary factor and that these inequalities exist regardless of the intersectional identities.

This could be misinterpreted as a philosophical dilemma within the context of Black men's multiple intersectionality's. Blackness is a primary inequality driver but, it should not be so reductionistic that it is seen in isolation from other intersecting identities such as gender, sexuality, class, and disability. Intersectionality theory highlights the double disadvantage and inequality that is experienced by people with mental illness who belong to multiple stigmatized social groups[55,56,57]. Interventions aiming to reduce these inequalities need to be flexible and targeted towards intersectionalities (gender, sexuality, etc) rather than universal (Black men) to effectively address systemic inequality. Therefore, the desire to be seen as more than monolithic is not to take away the Black identity from the man but from a desire to be seen as more than a negative stereotype and re-address the stigma, and trauma rooted within this. Addressing these negative perceptions and racial biases is an important step toward reducing predetermined projections of mental health behaviours on to Black men during detention. Creating environments where people feel as though they are safe, they have a voice, and they are listened to will ensure that there is a reduction in fear, frustration and readmission [48,52,53,54].

The studies included in the systematic review were subject to a quality review to minimise the number due to the time afforded through the funding of this part of the wider project. This in itself is a form of silencing. During the quality appraisal all grey literature was excluded.

This review is unique in that it moves away from the standard approach to reporting systematic reviews. Instead, it allows for the insights of people with lived experience and highlights the importance of collaboration and being flexible and responsive to people's needs and 'meeting people' where they are at. We are eternally grateful to those who have been brave enough to share their personal stories, and their vulnerability and honestly throughout the process. The team have reflected upon their own positionality which has impacted both positively and negatively on the journey at times. We understand how important it is to learn from such experiences and we anticipate we will reflect more fully on these in future research papers.

There is undoubtedly significant scope for the mental health detention experiences of Black men to be substantially improved upon given issues highlighted in this review and concerns raised more generally over recent decades. We make six recommendations for policy and practice based on this research. These are: patient involvement and clear communication; reducing disparities through anti-discriminatory policies and practice; the promotion of cultural competence; community campaigns, collaboration, and support for carers; monitoring and auditing; and improving future research through promoting coproduction.

Patient involvement and clear communication

Our research found that many patients felt that they lacked control in the decision-making regarding their treatment. Communication and assessment strategies that prioritise active listening, empathy, and understanding of patient's cultural and spiritual backgrounds, would promote a culture of respect and empathy within health and social care environments. Professionals should discuss the diagnosis with the patient, explore any reservations and their reasoning. For example, reforms to the Mental Health Act in England and Wales should include alternative treatments, therapies, social support and medicines as a valid form of care and treatment choices, or as part of a combination. At the centre of this decision should be the needs and voice of the individual.

Reducing disparities through anti-discriminatory policies and practice

The implementation and enforcement of antidiscrimination policies within mental health care settings would help to ensure that Black men receive equitable treatment, and that biases in referrals and admissions are minimised. These policies should address both direct and indirect forms of discrimination within the system. Policies should be transparent and regularly reviewed. Targeted interventions around compulsory admissions need to address factors such as cultural barriers relating to systemic racism, a lack of community support and understanding, and a lack of GP or healthcare access. Fear is the main reason that most Black men do not access timely interventions and why they are perceived as violent when being detained. Having policies that actively reduce this fear by ensuring humane treatment of individuals in crisis, alongside community interventions and stigma reducing campaigns would be of benefit.

The promotion of cultural competence

Cultural competency and understanding of spirituality and religion were lacking in the majority of the papers reviewed in this study. Bridging the gap between medical knowledge and spiritual healing can be affected through collaboration, integrating diverse therapeutic approaches, and involving those with lived experience to understand how mental health care can provide a more holistic experience to meet the needs of people from all backgrounds. Initially, this can be through integrating ongoing cultural competency training to healthcare professionals, collaborating with spiritual and cultural leaders, adapting existing interventions, and simply asking patients what they feel is the best treatment for their own mental health care. Efforts should be made to create culturally appropriate care that considers all aspects of a patient's identity, this could include their race, nationality, gender, sexuality, or class for example. Care that only acknowledges one aspect of who they are may improve their experiences in some capacity, but still fails to provide true person-centred care.

Community campaigns, collaboration, and support for carers

In several of the papers reviewed, community interventions including regularly accessing a GP, reduced the need for crisis interventions, leading to compulsory detention through

mental health legislation. Through campaigns to reduce the stigma of mental health in communities that we know have a high level of Black male detention rates, particularly within the Black African and Caribbean diasporas, people may start to seek support earlier. This, however, means that there needs to be an improvement to early intervention strategies, access to GPs, community-based mental health interventions, and support networks for at-risk individuals, in place for this to be successful. Additionally, support for caregivers is essential so that they can support and advocate for the needs of their loved ones.

Monitoring and auditing

Being aware of the issues around the disparities for Black men in mental health services should be subject to accountability. This means that monitoring and auditing should take place on a continual basis to ensure that psychiatric and mental health services are complying with changes to policy and practice, and are able to respond to any other issues that may occur in a timely manner.

Improving future research through embracing co-production.

There should be investment in future research to understand and mitigate further disparities, with an emphasis on evidence-based policy development incorporating co-production in collaboration with experts by experience. The findings from the research, and the silences within research uncovered in this paper was led by people with lived experience of detention or of caring for someone who has been detained. Future research should always be developed in co-production with service users and carers who have lived experience to create meaningful and transformative change including at operational and strategic levels. Research conducted with people with lived experience captures the mental health detention process from the perspective of the population that is actually impacted by services and gives Black people agency within academia and health and social care, institutions that have historically both exploited and excluded the racialised experience.

In conclusion, raising the voices of those that feel silenced is vital to changing services in a meaningful and sustainable way. Intrinsically racist practices are difficult to see as they are so embedded into the fabric of mental health services, and are commonly dismissed as 'that is the way it has always been done'. By conducting this review in co-production, and embedding the experienced voice throughout, we have shown that although academic research is addressing disparities, it can continue to perpetuate damaging assumptions. By presenting a systematic review alongside a discussion of silences, this study goes some way towards helping practitioners, policymakers, academics, family and friends, and other experienced mental health service users, see how easy it is to invoke discussion and to begin to unravel harmful and racist practices.

Limitations

This is the first time that we know of that anyone has tried to understand the silences that come from a systematic review. In some instances, this may not be determined as generalisable as the authors are a small group of experts and people with lived experience commentating on issues that are not largely reported on within so called high quality academic literature. We found that the majority of the recommendations we have made were from sources that did not get through the systematic review search strategy. So instead of saying that there is a limit to generalisability, we determine that the generation of discussion has led to information that is more recognisable to other people with lived experience of being detained under mental health legislation.

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