

Approved Mental Health Professionals (AMHPs) and the compulsory detention
of Black service-users under the Mental Health Act - An institutional
Ethnography

Renée Aleong

Doctor of Philosophy

University of York
School for Business and Society

September 2023

Abstract

People from Black ethnic groups in England are disproportionately detained under the Mental Health Act 1983 (as amended 2007) [MHA] compared to other ethnic groups. Several national policy initiatives and legislative reviews have been established to address this issue with no desired outcomes. Ninety-four percent of the approved mental health professional (AMHP) workforce comprises social workers. Central to the AMHP's statutory role is making decisions regarding the compulsory detention of individuals to hospital, a process that contributes to the overrepresentation of Black ethnic groups in detentions. There has been limited research into how these processes impact AMHP decision-making. This inquiry seeks to address this gap in knowledge, guided by the methodological and theoretical framework offered by Dorothy Smith's Institutional Ethnography.

This research adopted the standpoint of social worker AMHPs to develop contextualised understandings of the social and ruling relations that influence AMHP practice. Ethnographic fieldwork spanning 12 months across two local authorities in England involved interviewing 31 social worker AMHPs, focusing on their experiences with Black service-users during different phases of MHA assessments. The study explored the role of multi-disciplinary collaboration and textually mediated work within AMHP practice.

This inquiry is guided by two key research questions: *1. To what extent do the accounts of social worker AMHPs' experiences of coordinating MHA assessments with Black service-users reflect the "ideological" work of AMHPs? 2. When applying the least restrictive option and considering the social perspective in their decision-making, what factors influence AMHPs' consideration of whether to detain an individual under the MHA?* This study's findings underscore the pivotal role of the social perspective in AMHP decision-making. However, challenges arise in translating the social perspective into practice. Firstly, because the MHA Code of Practice lacks explicit guidance on how it should be enacted. Secondly, due to the structural and systemic disadvantages faced by Black people in Britain. This is marked by disparities in socio-economic mobility via pathways that include access to social capital - a key factor in AMHP detention decision-making. Findings delineate the role of pervasive systemic racism, which operates through structures that support or restrict access to the socio-economic determinants of mental health.

To address entrenched disadvantages, policies need to fundamentally reorient to acknowledge the intricate link between mental health and socio-economic mobility. This includes factors such as social capital, sustainable livelihoods, social cohesion, community belonging, educational attainment, and freedom from discrimination. For social work and AMHP practice, this means adopting more holistic, rights-based, and preventative approaches tailored to racialised communities, addressing the social, economic, and cultural determinants of mental health.

Keywords: Approved Mental Health Professional (AMHP), Mental Health Act 1983 (MHA), social capital, Black and Minority Ethnic, institutional ethnography, social work, social policy.

Declaration

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for a degree or other qualification at this University or elsewhere. All sources are acknowledged as references.

Dedication and Acknowledgements

This thesis is dedicated to my husband Roan and our two children Eli and Elyse, who are my inspiration and motivation.

For their contributions to my achievement, I gratefully acknowledge the following:

This study was supported by an Economic and Social Research Council, White Rose Doctoral Training Partnership Pathway +3 studentship [award reference 2279477].

I am grateful to the social worker AMHPs who gave up their time to participate in this study. Without you this research would not have been possible. Thank you for sharing your knowledge and experience. I was moved by your openness and dedication to your role.

My heartfelt thanks to my exceptional PhD supervisors, Professor Martin Webber and Dr Jenny Threlfall for your comments, guidance, patience and support throughout this process. I am grateful for your expertise, mentorship and belief in my potential as a scholar. Thank you for having faith in me and for your unwavering encouragement which sustained me through the challenges of a doctorate. You have been kind and generous in sharing your vast knowledge whilst providing thoughtful feedback and rigorous scrutiny. The knowledge gained from this study would not have occurred without your robust and critical academic approach. You have undoubtedly contributed to my growth as a social researcher and social worker.

I wish to thank my examiners, Dr Nicola Moran and Professor Frank Keating, for their thorough review and invaluable feedback. Their constructive critiques and insightful recommendations have greatly enriched this thesis.

My endless love and gratitude are to my husband Roan, for your sacrifice and support through my many sleepless nights, and for your patience and understanding throughout this process. Love and thanks to my two children for supporting me throughout this PhD and offering words of encouragement when I really needed them. Love and gratitude to all my extended family, my mother Germain Cumberbatch, my sisters Debora and Sharon, my in-laws and my friends for always believing in me. Thank you for inspiring me to pursue my dreams and for all your well wishes, thoughts and prayers along the way. We did it!

Table of Contents

Abstract.....	2
Declaration.....	3
Dedication and Acknowledgements	4
List of Tables and Figures.....	10
List of abbreviations.....	11
Chapter 1. Introduction	12
1.1 Statement of the problem.....	12
1.2 Context of Study	13
1.3 Concepts and terminology related to race and ethnicity	15
1.4 The use of race and ethnicity terminology throughout and for the purpose of this study	17
1.5 Coercive and restrictive pathways into and within the mental health system	19
1.6 Government initiatives to tackle inequalities	21
1.7 Plugging a gap in the literature	23
1.7.1 Theoretical perspectives which informed this study.....	24
1.7.2 Contributing to the knowledge base of AMHP practice	27
1.8 The role of the AMHP in adult mental health services	28
1.8.1 The unique role of social worker AMHPs	30
1.9 Purpose of the study.....	30
1.10 Theoretical framework and research questions	31
1.10.1 Research questions.....	31
1.11 Why is this study important to me?.....	31
1.11.1 My previous training and research.....	31
1.11.2 Developing this PhD research project	36
1.12 My ontological position	37
1.13 Thesis structure.....	38
Chapter 2. Literature Review	39
2.1 Considering the literature	39
2.1.1 Exploratory work	39
2.2 Early database searching	39
2.2.1 UK	40
2.2.2 International.....	41
2.3 Inclusion and exclusion criteria for literature review	41
2.3.1 Inclusion criteria	41
2.3.2 Exclusion criteria:.....	42
2.3.3 Evaluation tool.....	42
2.4 Later database searching	43

2.5 Review of the literature	46
2.5.1 What factors influence AMHPs' decision to detain?	46
2.6 Accountability	47
2.7 Assessment of risk.....	48
2.8 Emotional labour.....	51
2.9 Intuition.....	54
2.10 Alternatives to detention.....	55
2.11 Summary	58
2.12 What are disparities?	58
2.13 Ethnic disparities across socioeconomic indices.....	60
2.14 Contributory factors for ethnic disparities in socioeconomic and mental health indices	63
2.14.1 Poverty.....	64
2.14.2 Educational attainment	65
2.14.3 Housing.....	66
2.14.4 Employment	66
2.14.5 Criminal Justice	68
2.14.6 Trauma.....	69
2.15 Colonialism, migration and Black mental health	71
2.15.1 Emancipation and African-Caribbean migration to Britain	72
2.16 Summary	73
Chapter 3. Institutional ethnographic methods	74
3.1. Overview of chapter	74
3.2 Introduction	74
3.3 Reflexivity and envisioning a research need from my social location	74
3.3.1 The Influence of my practice and standpoint on the research	75
3.4 Ontological and epistemological considerations	77
3.5 Qualitative research methods.....	78
3.6 Critical research	78
3.6.1 Deciding to use institutional ethnography	80
3.7 Institutional ethnography as a theory	82
3.7.1 Examining institutional ethnography's ontology and epistemology	84
3.7.2 Ethnography vs. Institutional Ethnography	85
3.8 Institutional ethnography as a methodology.....	86
3.8.1 Key conceptualisations and terms in institutional ethnography.....	87
3.8.2. Institutional ethnography as a method of enquiry	89
3.8.3. Data Analysis in institutional ethnography.....	89
3.9 Limitations of institutional ethnography	90
3.9.1 Addressing the limitations of IE.....	91
3.10 Instruments of this institutional ethnography study	92

3.10.1 Ethical approval	92
3.10.2 Ethical and regulatory considerations	93
3.10.3 Research Strategy	95
3.11 This study's informants	95
3.12 Research settings and participants	97
3.12.1 Inclusion Criteria	97
3.12.2 Exclusion Criteria	97
3.12.3 Demographic of participants and research settings.....	98
3.13 Interviews	100
3.14 Texts.....	101
3.14.1 Trustworthiness and rigour	102
Chapter 4. Framework for data collection and analysis	107
4.1 Phase one data collection	107
4.2 Phase two data collection – moving locations.....	110
4.2.1 Data saturation	112
4.3 Procedure for data analysis	113
4.3.1 Phase 1: Familiarisation with the data	114
4.3.2 Working with texts during fieldwork.....	115
4.3.3 Phase 2: Sorting and coding the data.....	115
4.4 Presenting the data.....	119
4.5 Breakdown of chapters.....	119
Chapter 5. “Risky Business”	121
5.1 Introduction	121
5.2 Receiving the MHA assessment referral.....	121
5.3 Sub-theme: Contextualising, assessing and managing risks	121
5.3.1. Risk to self and/or others	123
5.3.2 Mandate for social control	126
5.3.3 What about risk from others?	127
5.3.4 The temporality of risk	129
5.3.5 Tensions related to justifications for referral.....	131
5.4 Summary.....	131
Chapter 6. “Lost In translation”	133
6.1 Understanding the individual being assessed.....	133
6.2 “Push-back”- Challenging other people’s perception of the person being assessed	134
6.3 Implications of non-engagement by the person being assessed.....	136
6.4 Stigma attached to social services	138
6.5 Cultural Misunderstandings.....	140
6.6 The use of interpreters	142
6.7 Negative stereotypes of Black people – “Big, Black and Bad?”	144

6.7.1 The Orville Blackwood Inquiry (1993)	144
6.8 Ethnic inequality within the workforce: Underrepresentation of Black and Minority Ethnic AMHPs and mental health professionals	146
6.8.1 Lack of ethnic diversity within AMHP workforce	146
6.8.2 Workforce initiatives	147
6.8.3 Implications for AMHP policy and practice	148
Chapter 7. "Is it a crime?"	149
7.1 Tensions with multidisciplinary and interdisciplinary working.....	149
7.1.1 AMHPs working relationship with section 12 doctors	149
7.1.2 AMHPs' working relationship with the police	150
7.2 Professional identity and autonomy as an AMHP	153
7.3 Issues with inter-agency working	153
7.4 Conveyance to hospital.....	154
7.5 The impact of social isolation on Black mental health	155
7.6 Disproportionate police involvement	156
7.7 Use of restraint and/or control tactics by police during MHA assessment	157
Chapter 8. "A cheeky look"	159
8.1 Lack of feedback from service-users.....	159
8.2 Accessing information after an MHA assessment	160
8.3 Lack of opportunities for formal follow-up after MHA assessment	160
Chapter 9. Discussion.....	162
9.1 Chapter overview.....	162
9.2 Integrated discussion	162
9.3 Racism and racialisation of Black people	163
9.3.1 The notion of "risk"	163
9.3.2 Risk work.....	165
9.4 Multi-agency working	166
9.5 Disproportionate use of Psychiatric Intensive Care Unit (PICU) beds	166
9.6 Systemic racism?.....	170
9.7 Systemic theory.....	171
9.8 Social capital and Black mental health.....	172
9.8.1 The link between social capital and compulsory detention	173
9.9 Enacting the social perspective in AMHP practice.....	174
9.9.1 Has the social perspective lost advocacy in policy making?.....	176
9.9.2 Locating the social perspective within MHA assessments	177
9.10 Summary	178
9.11 Implications and recommendations	178
9.11.1 Prioritise the principle of "social perspective" in legislative and policy reforms and consensus on how this will translate into AMHP practice	179

9.11.2 Policy initiatives that recognise and invest in the different forms of social capital deployed by Black people in the UK.....	180
9.11.3 Can Siegel’s framework be adapted to enhance mental health in Black communities?	184
9.11.4 Critical reflection of Siegel’s framework to improve population mental health.....	185
9.11.5 A consistent approach to AMHPs recording evidence of their considerations of “least restrictive alternatives” in MHA assessment reports.....	186
9.11.6 Better resourced alternatives to compulsory detention.....	187
9.11.5 Reduce the risk of re-traumatisation	187
9.12 Possibilities for the future.....	188
9.12.1 Future Research.....	188
9.12.2 Future practice	189
9.12.3 Dissemination	189
9.13 Limitations and challenges of this study.....	190
9.13.1 Impact of COVID-19 pandemic	190
9.13.2 Absence of observational work	190
9.13.3 Social worker AMHPs as standpoint informants	192
9.13.4 Limitations of the study.....	192
Chapter 10. Reflections and Conclusion	195
10.1 Reflexive review.....	195
10.1.1 My insider/outsider status	195
10.1.2 Emotional labour and resilience.....	196
10.2 Summary of the key contribution this study makes to the evidence base.....	197
10.3 Conclusion.....	198
References	200
Appendices.....	236
Appendix A: Research ethics Committee (REC): Favourable ethical opinion letter	236
Appendix B: Researcher response to REC conditions	243
Appendix C: REC Compliance with approval conditions letter	244
Appendix D : Participant information sheet	246
Appendix E : Participant consent form	253
Appendix F: Introductory email to participants.....	254
Appendix G: Interview Schedule.....	255
Appendix H: Interview Guide	256
Appendix I: Excerpt of interview transcript	257
Appendix J: Transcripts with coding	258
Appendix K: Text and document analysis	259
Appendix L: Refining emergent analytical themes	260

List of Tables and Figures

List of Tables

Table 1. Themes from reviews of the literature	43
Table 2. Results of databases searched	46
Table 3 Key strategies in assessing trustworthiness and rigour in qualitative research adapted from Lincoln and Guba (1985)	103
Table 4. My process of data analysis	105
Table 5. Orienting features in institutional ethnographic research (adapted from Bisailon 2012).....	109
Table 6. Organising the data	117
Table 7. Themes and sub-themes of research findings	120

List of Figures

Figure 1. Number of detentions under the Mental Health per 100,000 people, by aggregated ethnic group (standardised rates). Location: England. Time period: April 2021 to March 2022.....	13
Figure 2. Number of detentions under the Mental Health Act per 100,000 people, by individual ethnic group (standardised rates). Location: England. Time period: April 2021 to March 2022.....	14
Figure 3. Image of train on railway track used as a metaphor to envisage the various elements of the MHA assessment process (image adapted from cnn.com, 2022)	23
Figure 4. Pathway from the point an AMHP accepts a referral for a person with a mental health crisis to the point that an MHA assessment is completed.....	29
Figure 5. Thematic diagram of barriers to BME groups accessing mental health services in England.....	35
Figure 6. 'Boss Texts' used to coordinate and organise AMHP work activities	102
Figure 7. Qualitative data analysis: A Model of the Process (Seidel, 1998).....	111
Figure 8. Analytical mapping illustrating how institutions, people, work and texts are connected to informants' everyday work activities.....	119
Figure 9. Overview of pathway into inpatient care for a person presenting in mental health crisis	125
Figure 10. Flowchart showing how risk concerns are linked to requirement for police attendance at an MHA assessment.....	152
Figure 11. A framework for designing policy strategies and interventions to improve population mental health.....	182

List of abbreviations

Abbreviation	Meaning
AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
BASW	British Association of Social Workers
BME	Black and Minority Ethnic
CIT	Cultural Identity Theory
CMHT	Community Mental Health Team
CJS	Criminal Justice System
CQC	Care Quality Commission
CRHTT	Crisis Resolution Home Treatment Team
DHSC	Department of Health and Social Care
DOH	Department of Health
DRE	Delivering Race Equality
ESRC	Economic and Social Research Council
GDPR	General Data Protection Regulation
GP	General Practitioner
IE	Institutional Ethnography
LA	Local Authority
MH	Mental Health
MHA	Mental Health Act 1983 (as amended 2007)
MHSW	Mental Health Social Worker
MHT	Mental Health Trust
MMHA	Modernising the Mental Health Act
NHS	National Health Service
PICU	Psychiatric Intensive Care Unit

Chapter 1. Introduction

1.1 Statement of the problem

The overrepresentation of people from Black and Minority Ethnic (BME) groups is an established and contentious problem within contemporary mental health services in England. Specifically, people from Black ethnic groups have a long history of disproportionate compulsory detention under the Mental Health Act 1983 (as amended in 2007) [hereafter MHA] and have the highest rate of detention out of all ethnic groups (NHS Digital, 2022; Cabinet Office, 2018; Department of Health [DoH], 1999). A large body of evidence from research studies and national statistics have consistently shown that people in Black Ethnic groups - particularly Black Caribbean people - are overrepresented in their local detained populations and are more likely to be detained under the MHA (commonly known as being “sectioned”) than those in White ethnic groups. (Nazroo, 1997; Bhui et al., 2002; Keating et al., 2002; Nacro, 2007; Singh et al., 2007; Care Quality Commission [CQC], 2011; Anderson et al., 2014; NHS England, 2016; Cabinet Office, 2018; NHS Digital, 2022).

“The profound inequalities that exist for people from ethnic minority communities in access to treatment, experiences of care, and quality of outcomes following mental health service care are longstanding” (Modernising the Mental Health Act, gov.uk, 2018, p. 19).

These persistent ethnic inequalities in Britain’s mental health system have been documented for more than four decades (Singh et al., 2007; Bhui et al., 2003; Lammy, 2017; Gov.uk, 2021; NHS Digital, 2022). There have been wide ranging explanations for these ethnic disparities which include the various socio-economic disadvantages that Black people in Britain face including chronic experiences of trauma and social exclusion, racism, discrimination, unemployment, living in urban environments, poverty and culturally inappropriate mental health services (Cogan, 2020; Halvorsrud et al., 2018; Memon et al., 2016; Faulkner, 2014; Chorlton et al., 2012; Keating et al., 2002). These disadvantages operate at interpersonal, institutional and societal levels (Macpherson, 1999; Rabiee and Smith, 2013; Nazroo, 2003; Bradby, 2010; Sashidharan, 2003).

Moreover, the varied reasons for these disparities have resulted in debates about causal factors. These include differing explanatory frameworks of mental health, cultural health beliefs about mental health, or unfounded assumptions about Minority Ethnic groups such as wider drug use or greater stigma attached to mental illness (Keating et al. 2002; Barnett et al., 2019). This is compounded by the lack of research in this area and the continued reliance on inconclusive or untested explanations which become problematic when they are used in the context of individuals living in diverse communities with varied lifestyles, cultural and religious beliefs.

1.2 Context of Study

The United Kingdom (UK) is a multi-ethnic and multicultural society where the population of Minority Ethnic groups is steadily increasing. The 2021 census showed 18 percent of the population identified as being from an Ethnic Minority background and people from Black ethnic groups represent 4 percent of the general population (ons.gov.uk, 2022).

The latest statistics for detentions under the MHA include people who were detained in hospital for assessment or treatment under the Act. Figure 1 shows that out of the five broad ethnic groups, people from the Black ethnic group were the most likely to have been detained under the MHA in the previous two years up to March 2022 at a rate of 342 detentions per 100,000 population. Rates of compulsory detention for people in Black ethnic groups were over four and a half times those in White ethnic groups, which had the lowest rate of detention at 72 detentions per 100,000 population (gov.uk, 2022).

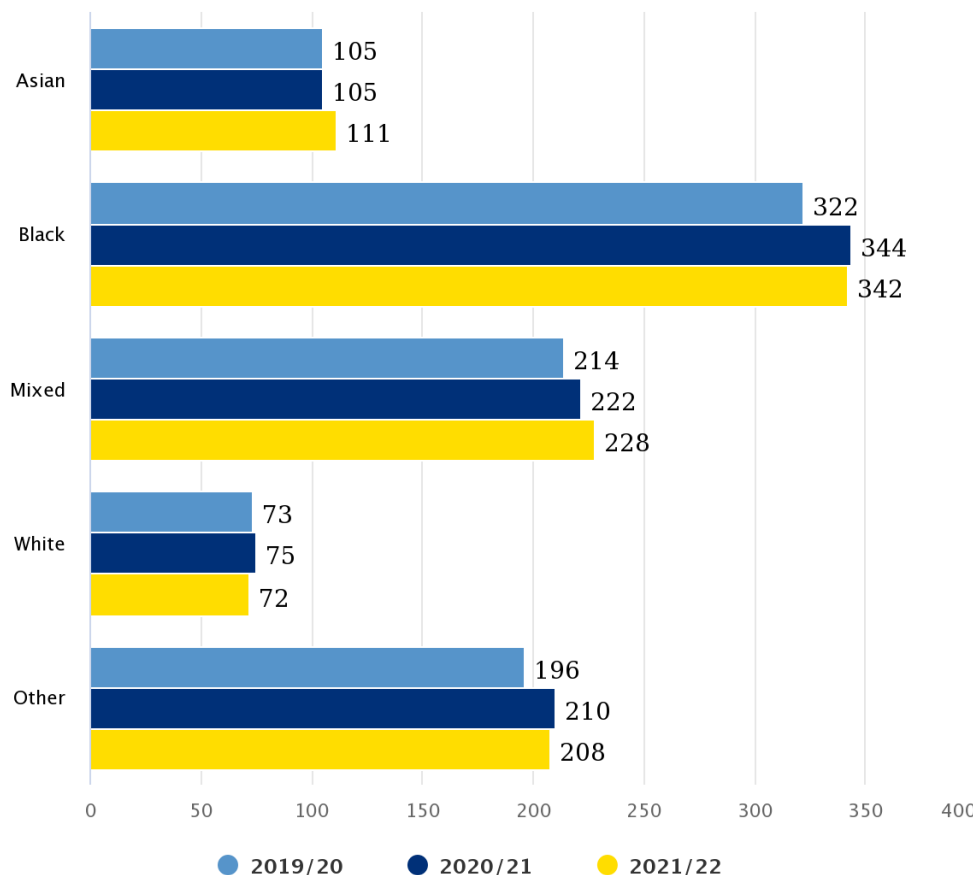


Figure 1. Number of detentions under the Mental Health per 100,000 people, by aggregated ethnic group (standardised rates). Location: England. Time period: April 2021 to March 2022

Source: Gov.uk (2023)

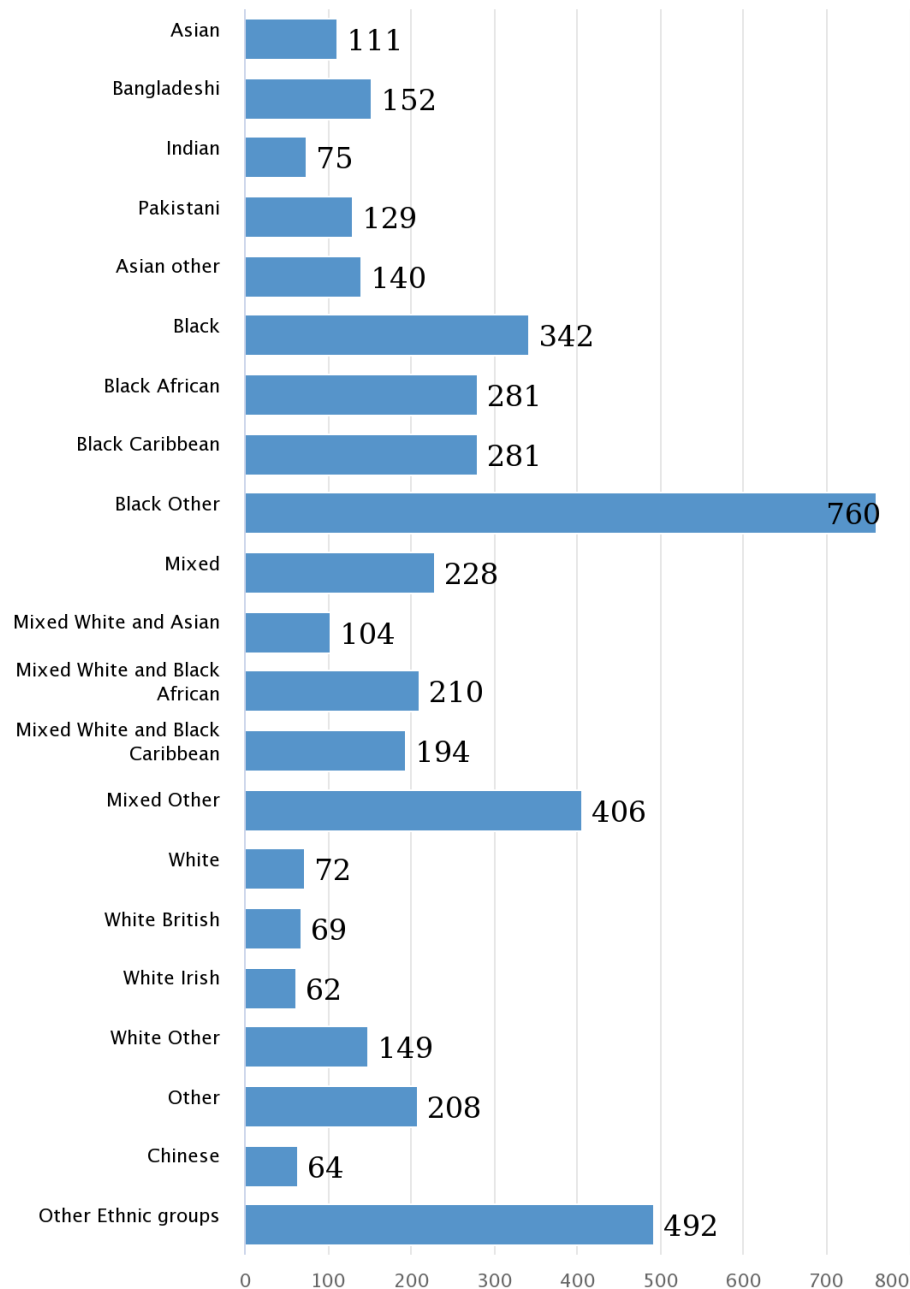


Figure 2. Number of detentions under the Mental Health Act per 100,000 people, by individual ethnic group (standardised rates). Location: England. Time period: April 2021 to March 2022
 Source: Gov.uk (2023)

Figure 2 provides a more detailed breakdown of detention rates for the five broad ethnicity groupings for the period 2021-2022. This shows the highest rates of detention were for the “Black Other” (760 detentions per 100,000 population) which is 11 times the rate for the White British group (69 detentions per 100,000 people) in 2021- 2022. “Other ethnic” groups (492 detentions per 100,000 population) and “mixed other” groups (406 detentions per 100,000 population) had the second and third highest rates respectively however, these rates are considered to be overestimates because ‘other’ categories may have been used for people whose specific ethnicity was not known. Additionally, the actual rates of detention

for people in the ethnic groups not labelled as “other” may be underestimated, particularly those within the Black ethnic groups (gov.uk, 2022).

The lowest detention rates were for the White Irish (62 detentions per 100,000 people), Chinese (64 per 100,000), White British (69 per 100,000) and Indian (75 per 100,000) ethnic groups. Overall, it is estimated that detention figures for the year to March 2022 increased by 0.2 percent from the previous year – this is based on figures from service providers who submitted good quality data in each of the last two years, rather than all providers (NHS Digital, 2022).

These detention figures do not include detentions following use of section 136 of the MHA (S136 MHA) and revocation of Community Treatment Orders (CTOs). CTOs are a legal mechanism provided for under S17A-G MHA, which sets out the legal framework for CTOs, including the criteria for eligibility, the role of AMHPs and responsible clinicians, the conditions and requirements of the order, and the processes for review and discharge. The aim of a CTO is to enable individuals with severe mental health disorders to receive treatment and support while residing in the community rather than being hospitalised. CTOs are typically applied when specific criteria are met, including the individual's need for ongoing treatment, the risk they may pose to themselves or others, and their lack of insight into their condition. CTOs impose conditions and restrictions on individuals' activities, such as attending appointments, residing at a designated address, or refraining from substance use (DHSC, 2021). These orders have a defined duration and undergo periodic review to assess the individual's progress and determine the need for continuation, modification, or discontinuation. Importantly, individuals subject to a CTO retain legal rights, including the right to appeal decisions, challenge conditions, and seek legal representation (DHSC, 2021). CTOs have been in use in England and Wales since 2008; however, their effectiveness has been widely debated (Gupta et al., 2008; Manning et al., 2011). While CTOs aim to provide necessary treatment and support in a less restrictive setting, concerns regarding autonomy, coercion, and the balance between therapeutic intervention and individual rights have been subject to debate and scrutiny.

The ethnic groupings used for rates of detention by broad ethnic group follow the 2021 Census groupings (ons.gov.uk, 2022), which are still used in the NHS. There are early indications that the adverse mental health consequences of the COVID-19 pandemic might also be disproportionately affecting ethnic minorities (gov.uk, 2022). However, evidence on ethnic inequalities in the indirect health consequences of the pandemic on non-COVID-19 health outcomes remain limited.

1.3 Concepts and terminology related to race and ethnicity

The word ethnicity is derived from the Greek words *ethnikos*, meaning “foreign” and *ethnos* meaning “nation” (Harper, 2020). Ethnicity is a multi-faceted characteristic that refers to large groups of people who share or are perceived to share language, diet, racial, cultural, religious, and/or other characteristics

in common including geographical and ancestral origins. The characteristics that define ethnicity are not fixed or easily measured, so ethnicity is imprecise and fluid as it includes facets of the concept of race (Senior & Bhopal, 1994; Bhopal, 2004)

The biological concept of race refers to a person's physical characteristics, such as bone structure, skin, hair and eye colour. This concept was dominant from the early 19th century whereby human populations were divided into sub-species mainly on the basis of visible physical characteristics however, this concept declined with the defeat of the Nazis at the end of the Second World War (Senior & Bhopal, 1994). The modern concept of race emphasises its social origins rather than its biological basis (Bhopal, 1997). This concept of race allows for the defining, for social purposes, populations that look different and have different ancestral roots (Kaplan, 2003). However, this social concept of race is also based on physical and hence biological factors. Bhopal (2004) warns that the term race should be used with caution due to its history of injustice and misuse, particularly in the study of racism, where the concept is central. According to Bhopal (1997) the concepts of ethnicity and race in health and scientific research raise difficult ethical issues, which have rarely been explicitly considered by scholars.

Despite having different meanings, the terms race and ethnicity are intersecting concepts that are often used synonymously. This trend has been adopted, particularly in the United States (US), with increasing use of the compound word race/ethnicity (Bhopal, 2004). This trend reflects the practical and conceptual difficulties in considering the concepts of race and ethnicity separately. In contrast, in Europe ethnicity is favoured over race in scientific literature (Aspinall, 2002; Bhopal, 2004), this reflects emerging worldwide trends, which suggest that ethnicity is in the ascendancy (Aspinall, 2002; Afshari & Bhopal, 2002; Kaplan, 2003). Despite these developments, there is no consensus on appropriate terms for the scientific study of health by ethnicity, and published guidelines are yet to be widely adopted (Bhopal, 2004).

Moreover, there is often a debate around the terminology used to refer to communities minoritised in relation to the local population on the basis of their racial or ethnic origin (Okolosie et al., 2015). No single term is fully capable of capturing the vast diversity, difference and similarity within these communities. For instance, Caribbean people are the descendants of many peoples who have shaped their history and culture. The main ethnic groups in the Caribbean are: Indigenous Peoples, Africans, Indians, Europeans, Chinese and Portuguese (The Caribbean Community [CARICOM], 2022). As a Trinidad born Caribbean native of mixed Indigenous Peoples and African descent living in Britain, I found the conventional British labels; "Black," "African-Caribbean" and "Black Caribbean" to describe the ethnic ancestry of people like me or from the region where I was born as rudimentary. However, during the course of my research I realised that these labels are embedded in the health and scientific literature as well as NHS and census data (Bhopal, 2001; Agyemang, Bhopal & Bruijnzeels, 2005; ons.gov.uk, 2022; NHS Digital, 2022; gov.uk 2020a).

Today, the labels “Black Caribbean” and “African-Caribbean” are used interchangeably to describe people of Caribbean descent. However, many, including me, have strong opinions that the label “African-Caribbean” is too restrictive for the current British population (Agyemang, Bhopal & Bruijnzeels, 2005; Bhopal, 2004). In part, the term African-Caribbean came into use to highlight that the experiences of the people in Britain reflect both their origins in the African continent and their history in the Caribbean. But recent immigrants from Africa and the Caribbean have different combinations of history and experience; so some have argued that the term “Black” although still restrictive, is more inclusive of the collective experiences of the British population. These views are supported by findings of the 2021 census, which show that the majority of Caribbean born people living in England and Wales identified as Black Caribbean (ons.gov.uk, 2022).

Popular terminology for Ethnic Minority populations for example, Asians and Blacks may suffice for everyday conversation, however when used in research, the underlying concepts and an accurate definition ought to be discussed (Bhopal, 1991; Aspinall, 2002). Bhopal (2004) argues that in practice, a clear definition of what is meant by the terms ethnicity and race is often lacking in the literature making it difficult to compare studies, particularly internationally. Further, Bhopal (2001) asserts that purpose and context should be the prime determinants of the way that race and ethnicity concepts are applied, classifications are devised and used, and data are analysed and presented by those undertaking health research related to race and ethnicity. This is not surprising as race and ethnicity are complex, multidimensional concepts changing with time and therefore subject to varying interpretations. In chapter two, we will continue these discussions by reviewing the literature which examines the ways in which race and ethnicity have been operationalised in social research, including a discussion of the implications for conceptualisations of race and ethnicity as it relates to Black mental health.

1.4 The use of race and ethnicity terminology throughout and for the purpose of this study

In England and Wales, there are 18 ethnic groups recommended for use by government when they ask for someone’s ethnicity. These are grouped into five broad ethnic groups namely: Asian, White, Black, Mixed and Other (gov.uk, 2020a). This study has followed the general conventions of these broad groupings used in England and Wales and, whenever appropriate, the terminology used by original authors. For example, in the UK the term “Minority Ethnic” usually but not always refers to minority populations of non-European origin and characterised by their non-White status (Bhopal, 2004). It is also used to describe specific identifiable groups, for example, Gypsy and Roma travellers, and less commonly, Irish in the UK. Some people consider the phrase inaccurate and prefer “Ethnic Minority,” but the two phrases are used synonymously. Terms and phrases used to describe racial and ethnic groups are designated by proper nouns and capitalised throughout this thesis to signify their specific use in this way (Nguyen & Pendleton, 2020).

The term “Black” is used to collectively denote a person with African ancestral origins, who self identifies, or is identified as Black, African, African-Caribbean, Afro-Caribbean or Black British. The term “Black and Minority Ethnic” or “BME” is used in this study to collectively refer to people with African, Caribbean, African-Caribbean, Asian, or dual/multiple heritages, refugee and asylum seeker communities. This also includes people who regard themselves as Black British or British Asian as well as White ethnic minorities such as Gypsy, Roma and Traveller of Irish Heritage groups. Although the term BME is widely used by government departments, public bodies, the media and others when referring to Ethnic Minority groups, it is contentious and despised by many (Okolosie et al., 2015; Parris, 2016; Sandhu, 2018; Bunglawala, 2019). Personally, I have never referred to my ethnicity using the abbreviation “BME,” and I do not like it when it is used to describe me. The fact that it has been called into question suggests that I am not alone. The term “White” is used to describe people with European ancestral origins who identify, or are identified, as White. The term “Asian” applies to people originating from the Asian continent. In practice, this term is used in the United Kingdom to mean people with ancestry in the Indian subcontinent (Bhopal, 2004). The term “Mixed” is used to describe people who identify or are identified as White and Black Caribbean, White and Black African, White and Asian and any other Mixed /Multiple ethnic background. The word is capitalised to signify its specific use in this way. The term “Other” is commonly used in UK census data (ons.gov.uk.2022) and denotes people who do not identify or are not identified as belonging to a particular ethnic group. Without this individually small, but collectively large group, populations risk being hidden when policy on ethnic diversity is made. The word is capitalised to signify its specific use in this way. The term “general population” refers to everyone in the population irrespective of their race or ethnicity.

As implied, the concepts of ethnicity and race within health and scientific research are debateable. Furthermore, there is no consensus on appropriate terms for use in the scientific study of health by ethnicity and race and published guidelines on how to use these concepts, from a number of journals, are yet to be widely adopted (Bhopal, 2004). This means that the measurement or assignment, of ethnicity is problematic despite much research and debate. It is acknowledged that the preferred groupings in the UK that are also used throughout this study, such as Black, BME, African-Caribbean, White, and Asian hide massive “within group” heterogeneity. This may diminish the value of ethnic categorisation as a means of delivering culturally appropriate mental health care and raises uncertainty about the generalisability of findings from research to populations that fall within the same ethnic group but have different subgroup profiles (for example, Black people with different places of birth, country or region of origin within the Caribbean or African continent).

The international interest in, and the influence of, studies on ethnicity and race is growing. It is therefore important that the conceptual basis of the research is sound (Møllersen & Holt, 2008). Despite this, there is currently no standard definition of ethnicity, and the choice of terminology varies and tends to reflect the ideology and theory of each researcher as well as current trends and policies (Juby & Concepción, 2005). In order for this issue to be adequately addressed there needs to be agreement on an internationally

acceptable and comprehensive glossary of terms to describe race and ethnicity. This is a massive undertaking but if the subject is to advance it needs to be tackled.

From an international perspective, it is argued that in the field of health there is a case for leadership from a partnership including the World Health Organisation, and the World Association of Medical Editors (Bhopal, 2004). However, the UK government published the Race Disparity Audit (RDA) in October 2017. The aim was to show how people of different ethnicities are treated across public services by publishing data held by the government. One of the objectives of the RDA included the improvement of the consistency and robustness of the data it collects on the basis of ethnicity (gov.uk, 2020b). As part of general improvements to ethnicity data, the RDA examined: “the challenges of harmonising ethnicity classifications across government and other sources of data” and “the statistical implications of clustering different Ethnic Minority groups in particular areas” (gov.uk, 2020b). This was intended to be a 2-year work plan starting from April 2020 (gov.uk, 2020b).

1.5 Coercive and restrictive pathways into and within the mental health system

People from Black ethnic groups also face more coercive and restrictive pathways into and within the mental health system including: through police (under S136 MHA); higher rates of CTO use; being subject to excessive medicalisation (Basnal et al., 2022; Fatimilehin & Coleman, 1999); locked wards and forensic services (Nacro, 2007; Tarbuck et al., 1999) and lack of psychological interventions such as talking therapies to reduce their mental ill health (Glover & Evison, 2009). Additionally, Black people are ten times more likely to be subjected to supervised treatment with conditions once discharged from hospital when compared to people from White British backgrounds (NHS Digital, 2022; Barnett, 2019) and are the highest rate of detained people subject to repeated detention (NHS Digital, 2022). These inequalities are reflected across all indices of economic and social well-being and manifests for Black groups as poorer housing; poorer health; higher rates of unemployment; lower levels of academic achievement, higher rates of exclusions from schools and overrepresentation within the courts and criminal justice settings (White, 2002; Sewell, 2012; Cabinet Office, 2018).

There is substantial evidence to suggest that compulsory psychiatric admission has been associated with a diagnosis of schizophrenia and related disorders, ethnicity, risk, gender, unemployment, lack of social support, dangerousness and differences in legal criteria for involuntary admissions across countries (Vinkers, 2010; Singh et al., 2014; Keating, 2016). The disproportionality of Black groups in compulsory detention under the MHA has been attributed to several factors such as: higher rates of psychosis in people from Black ethnic groups, lower or delayed help-seeking, mistrust of services and others service-related factors such as misdiagnosis, institutional racism, poorer recognition at primary care level and hence a

delayed, crisis presentation to services (Basnal et al., 2022; Aleong, 2018; Memon et al., 2012; Singh et al., 2007).

Detentions amongst Black groups are also statistically greater than those from a White British ethnicity amongst adolescent psychiatric admissions (Tolmac & Rhodes, 2004), first-episode psychosis (Mann, Fisher & Johnson, 2014) and severe and persistent mental health conditions (Singh et al., 2014). However, the prevalence of common mental disorders varies markedly in different BME communities. For example, South Asian women encounter higher rates of anxiety and depression (63.5 percent compared with 28.5 percent of White women). Additionally, there is a significantly higher prevalence of psychotic disorders or episodes in Black men (3.2 percent compared with 0.3 percent of White men) [gov.uk., 2021]. The Schizophrenia Commission (2012, p. 49) argues that “These high rates are not found in the Caribbean, indicating that it is not being black that increases the rates but being black in Britain.” Despite the marked cultural differences between Black Caribbean and Black African people, both ethnic groups have increased rates of psychosis in clinical studies in Britain (Qassem et al., 2015). This is thought to be because people from Black ethnic groups share distinguishing physical features, thus share the experience of discrimination and consequent social disadvantage which may be the main driver of the high rates of psychosis (Qassem et al., 2015).

There has also been an emerging pattern regarding the utilisation of mental health services among Ethnic Minority groups, which points towards differential and inequitable experiences and outcomes. In general, people from Ethnic Minority groups are less likely than their White British counterparts to have contacted their general practitioner (GP) about mental health issues, resulting in a greater likelihood of being prescribed anti-depressants or being referred to specialist mental health services (Keating et al., 2002; Fatimilehin & Coleman, 1999). A number of explanations for this can be identified in the literature. Firstly, it has been argued that BME people are not perceived as capable of benefiting from psychotherapeutic approaches, due to cultural and linguistic differences. A cross-sectional national study found that relative to White service users, Ethnic Minority service users with psychosis were generally less likely to be offered a range of evidence-based treatments for psychosis, which included pharmacological and psychological interventions as well as involvement in care planning (Das Munshi et al., 2018). Researchers have suggested that Asian people have a tendency to somatise psychological distress and this has led to a myth that they are unable to utilise talking therapies (Islam et al., 2015). Secondly, it has been suggested that BME people are less likely to approach formal services when they first become aware of a problem. This may be because BME families have little confidence in the ability of services to understand and meet their needs and have had negative experiences with statutory services in the past (Keating et al., 2002; Fatimilehin & Coleman, 1999). Language barriers prevent people from BME groups accessing information about existing services (Memon et al., 2016; Barron et al., 2010). Finally, discriminatory attitudes held by many mental health and primary care professionals may mean that less coercive forms of intervention are not offered at all (Keating et al., 2002).

Studies that have investigated factors that predict the outcome of MHA assessments and detentions in the UK have revealed a complex and multi-faceted relationship between ethnicity and detention. Amongst women experiencing mental health crisis (Lawlor et al., 2012) and first-episode psychosis (Mann et al., 2014) in London, high rates of compulsory detention in Black women were partially explained by poor help-seeking behaviour and differences in pathways to care. In a longitudinal study of all adolescent psychiatric admissions in London from 2001 to 2010, Corrigan and Bhugra (2013) found that adolescents from a Black ethnic group with a diagnosis of psychosis were three times more likely than the White British group to be detained, but there was no ethnic variation in non-psychotic detentions with statistical significance. In reviewing the relationship between mental health services and African and Caribbean communities, Keating et al. (2002, p. 24) discuss “circles of fear” – the perception and experience of unfair and unequal treatment in mental health services, which lead to poorer treatment of Black communities within mental health services in England.

Some studies have found that ethnic disparities in compulsory admission are reduced or eliminated once confounding factors such as age, gender, diagnosis, risk and pathways to care are controlled for (Singh et al., 2007; Lawlor et al., 2012; Corrigan & Bhugra, 2013; Singh et al., 2014). However, in other studies BME status remained an independent predictor of psychiatric detention (Morgan et al., 2005; Singh et al., 1997), with ethnic variations between BME groups in experiences of mental health services (Raleigh et al., 2007). Increased use of mental health services and elevated incidence of suicide globally (Ritcher et al., 2019; Furukawa, 2019) have thrust the importance of mental health into public consciousness. The emphasis on mental health has gained widespread attention as healthcare professionals attempt to find more effective ways of managing mental illness (Mind, 2013a).

The plight of Black mental health points to a failing of institutional services that have a designated remittance to support the mental well-being of these individuals. Within health-related research, people from BME communities continue to be under-represented. As a direct consequence, there remains a dearth of literature that has examined extensively the effects of mental health on people from BME backgrounds and communities within professional environments. Over the past decade, researchers (Basnal et al., 2022; Faulkner, 2014; Islam et al., 2015; Keating, 2019; Memon et al. 2016) have attempted to highlight the consequences of mental health issues and inequalities when not adequately addressed regarding equitable experiences within mental health services.

1.6 Government initiatives to tackle inequalities

What is striking, is that these inequalities persist despite government implementation of various race equality strategies which aim to promote equality in mental health services (Sashidharan, 2003; Nacro, 2007). The Race Disparity Audit (Cabinet Office, 2018) which examined how people of different ethnicities are treated across public services, discovered ethnic disparities in health and mental health care, education and criminal justice. The emerging pattern revealed BME people’s experience of the

mental health sector mirrored other forms of socio-economic disadvantage happening in British society: higher levels of unemployment, poverty, poor housing, poor secondary school attainment, higher secondary school expulsion rates, racism and disproportionate representation within the criminal justice system [CJS] (Nacro, 2007; Cabinet Office, 2018). Ethnic disparities in detention rates under the MHA continue to persist despite government initiatives and have in fact worsened over the past two decades. Examples of these initiatives are: ‘Inside Outside: Improving Mental health Services for Black and Minority Ethnic Communities in England’ (Sashidharan, 2003); ‘Delivering Race Equality (DRE) Strategy’ (DoH, 2005), a five year action plan aimed at tackling discrimination and achieving equality within mental health services in England; the ‘Count Me in Census’ (CQC, 2011); ‘No Health Without Mental Health’ (HM Government, 2011) which acknowledged risk factors for people from BME communities and ‘The Five Year Forward View for Mental Health’ (NHS England, 2016) which recommended a review of the MHA in response to increasing numbers of detentions of people from BME groups. In response to the stark inequalities reported in the findings of the ‘Five Year Forward View for Mental Health’ former UK Prime Minister Theresa May commissioned Professor Sir Simon Wessely to chair a review of the MHA in 2017 (gov.uk, 2018). One of the main aims of the review was to investigate the disproportionate numbers of patients from BME backgrounds detained under the MHA annually, with the aspiration to reduce the number of compulsory detentions (Rethink Mental Illness, 2017). The Independent Review of the MHA titled ‘Modernising the Mental Health Act,’ [MMHA] (gov.uk, 2018) acknowledged that:

“...those from Ethnic Minority communities are far more likely to be subject to compulsory powers under the Act, whether in hospital or in the community. Even amongst that group, black African & Caribbean men are significantly over-represented... We are in no doubt that structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in Ethnic Minority communities. There is no single or simple remedy to resolve this situation, which is not unique to the health service in general, or mental health services in particular. A similar and equally depressing picture can be painted within our schools or criminal justice system or other aspects of modern society. No other issue has made us more aware of our fallibility than this one.” (gov.uk, 2018, pp. 19-20).

The MMHA review found that the MHA is in need of significant reform and proposed a range of changes to improve mental health services. The Government carried out a consultation about the recommended reforms in 2021 and published its response titled ‘Reforming the Mental Health Act [White Paper]’ (Department for Health and Social Care [DHSC], 2021), which sets out proposed changes to the MHA and wider reforms of policy and practice around it. Included in the White Paper are plans to tighten the admission criteria and raise the threshold for compulsory detention; reduce the use of community treatment orders; and improve the experiences of persons from BME groups. Despite the Government’s 2019 manifesto pledge to reform the MHA (Institute for Government, 2021), it has yet to bring a bill to

the Commons to implement changes which require legislation and says it will do so “when parliamentary time allows” (Lay, 2023).

1.7 Plugging a gap in the literature

This study explores the institutionally and discursively organised systems, people and processes that interact whilst AMHPs coordinate, organise and contribute to the MHA assessment. At the start of this research project, I used the metaphor of a train on a railway track as a simplistic analogy to envisage the known components that organise AMHP work. I imagined the train as the local authority with the AMHP as the train driver. The person subject to the MHA assessment was a passenger on the train. The rails represented the MHA assessment process and the destination the AMHP’s decision to either detain or seek least restrictive alternatives. The ballast layer was the foundation represented by the MHA, the MHA Code of Practice (DHSC, 2015), case notes, other texts, legislative policies and procedures that underpin and mediate AMHP work. The sleepers intersect the track, and represented the various institutions, professionals and people whom the AMHP interacts with during the MHA assessment process such as the nearest relative, carers, S12 doctors, nurses, police, social workers, conveyance providers and other professionals. My challenge and analytical work in this study was to explicate and uncover how this railway system is put together to act as the starting and ending point of the MHA assessment and AMHP decision-making process. I was aware that aspects of AMHP work might also involve more invisible or not immediately observable undertakings (Smith, 2005; DeVault, 2014). Hence, I set out to explore and analyse how AMHP work activities are connected to institutional arrangements and ruling relations and how this may impact decisions to detain people from Black ethnic groups. This metaphorical image is illustrated in Figure 3.

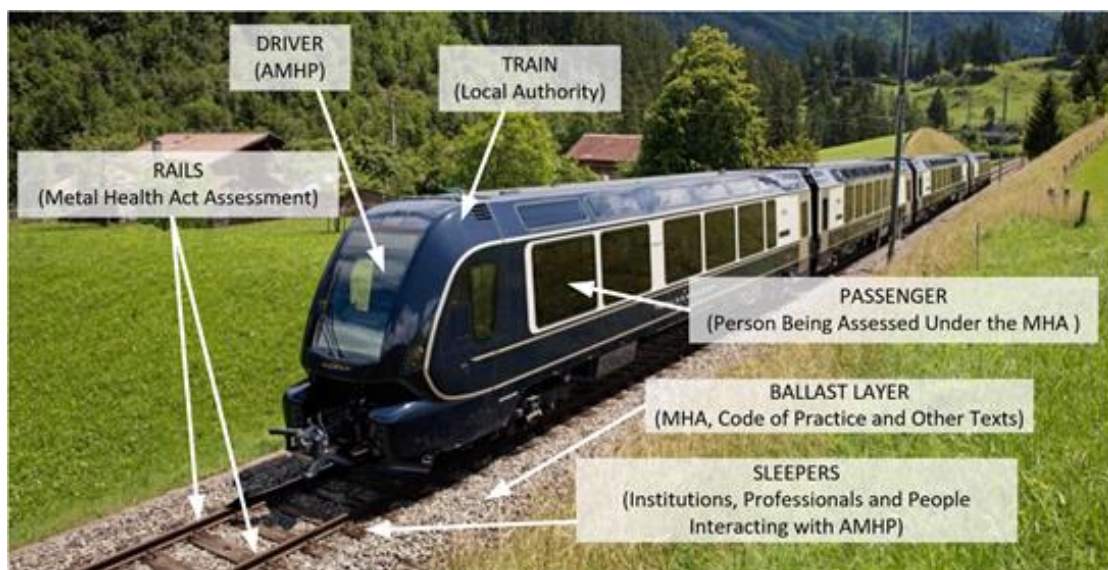


Figure 3. Image of train on railway track used as a metaphor to envisage the various elements of the MHA assessment process (image adapted from cnn.com, 2022)

The operational and institutional structures within AMHP work processes could impact the detention of Black service-users, as MHA statistics show specific and continuing disproportionality in the rates of compulsory detention for this group (NHS Digital, 2022; CQC, 2022; gov.uk, 2022). Institutional ethnography [IE] (Smith, 1987, 1990, 2005, 2006) is utilised as the primary guiding methodology and social theory of this study. I used IE's concept of "work" referring to people's doings and their expert knowledge about their doings (Smith, 2005, DeVault, 2014) as an analytical lens to start organising the data around informants' accounts of the work activities involving Black and/or Minority Ethnic service-users. IE guides the researcher to discover and examine the problematic through which to better understand a particular phenomenon. By applying institutional ethnographic methods (Smith, 2005, 2006), I was able to identify and describe the systematic processes and embodied practices that define the specific operations and decision-making during MHA assessments. This entailed examining how: risk is assessed, the "least restrictive" option is applied, the "social perspective" enacted and interdisciplinary working is mediated using texts which organise and coordinate decision-making by AMHPs.

1.7.1 Theoretical perspectives which informed this study

Critical realism (Oliver, 2012; Bhaskar, 2007; 2015; Archer, 2005); social constructionism (Proding and Turner, 2013; Schreiber & Valle, 2013; Berger & Luckmann, 1966) and cultural identity theory (Collier and Thomas, 1988) informed this study by providing theoretical perspectives.

1.7.1.1 Critical realism

Critical realism offers a robust theoretical perspective when applied to IE studies, providing a framework that enables researchers to uncover the underlying structures and mechanisms shaping social phenomena within institutions (Bhaskar, 2007; 2015). This perspective emphasises the importance of understanding reality in terms of multiple layers or levels, moving beyond surface-level observations to explore the underlying structures, mechanisms, and causal powers that influence social practices within institutions (Oliver, 2012).

In the context of IE, critical realism focuses on identifying the generative mechanisms that produce observable phenomena (Bhaskar, 2015). Researchers investigate how institutional structures and processes generate specific practices and outcomes, such as exploring how bureaucratic rules and procedures influence patterns of behaviour among institutional actors. Moreover, critical realism underscores the significance of context in shaping social practices within institutions (Archer, 1995). Researchers are encouraged to situate their analysis within broader socio-political and historical contexts to better understand why certain institutional arrangements exist and how they impact individuals' experiences and identities. Critical realism facilitates a nuanced analysis of the interplay between agency (individual actions) and structure (social contexts and institutions) within institutions (Archer, 1995). Researchers can examine how individuals' actions are influenced by larger structural forces while recognising individuals' capacity to shape and contest institutional practices.

Additionally, critical realism acknowledges the emergence of new phenomena resulting from interactions within complex social systems (Bhaskar, 1978). This perspective allows researchers to explore how institutional practices and relationships give rise to emergent patterns of behaviour or unintended consequences within institutional settings. Furthermore, critical realism encourages reflexivity about the researcher's role and the nature of knowledge production in institutional ethnography (Oliver, 2012; Archer, 1995). Researchers critically examine their assumptions, methods, and interpretations to enhance the rigour and validity of their study.

Finally, critical realism supports an emancipatory approach to research by highlighting the potential for social change (Bhaskar, 1978). By uncovering the underlying structures and mechanisms perpetuating inequalities or injustices within institutions, researchers can identify leverage points for intervention and advocacy aimed at addressing social challenges within institutional contexts.

In summary, critical realism enriches this IE study by providing a theoretical lens that helps the researcher uncover the deeper mechanisms and dynamics at play within complex social systems (Archer, 1995). This perspective encourages a holistic understanding of institutions shaped by historical, structural, and agential factors, informing both scholarly debates and practical efforts to address social issues within institutional settings.

1.7.1.2 Social constructionism

Social constructionism offers a valuable theoretical framework for conducting IE studies by focusing on how social phenomena, including institutions, are constructed through social processes and interactions (Prodinger & Turner, 2013). Firstly, social constructionism emphasises that institutions, along with their norms, rules, and practices, are not inherently given or natural but are socially constructed through shared meanings and interactions (Prodinger & Turner, 2013). In an IE study, this perspective helps researchers examine how institutional realities are created, sustained, and transformed through ongoing social processes.

Secondly, social constructionism highlights the role of language and discourse in shaping institutional life (Schreiber & Valle, 2013). Researchers conducting an IE can utilise this framework to analyse how discursive practices within institutions such as official documents, policies, and interactions, contribute to the construction of institutional identities, roles, and power dynamics. Social constructionism challenges essentialist views that portray institutions as static or immutable entities, instead encouraging researchers to explore the dynamic and contingent nature of institutions (Prodinger & Turner, 2013). This perspective acknowledges that institutions are continually (re)created through social interactions and negotiations.

Moreover, social constructionism directs attention to power relations within institutions (Schreiber & Valle, 2013). Researchers can investigate how power is exercised and contested through discursive practices and institutional arrangements, uncovering how certain groups or individuals influence the construction and maintenance of institutional norms and practices. According to Prodinger and Turner, (2013), social constructionism encourages researchers to focus on social processes rather than fixed structures in IE. This approach involves examining how everyday interactions and routines contribute to the construction of institutional realities, and how individuals negotiate their identities and roles within institutional contexts. Furthermore, social constructionism recognises the existence of multiple and sometimes conflicting realities within institutional settings (Berger & Luckmann, 1966). This perspective allows researchers to explore diverse interpretations and experiences of institutional life among different stakeholders, providing insights into the complexity and diversity of institutional phenomena.

Lastly, social constructionism promotes reflexivity by encouraging researchers to critically reflect on their own roles and assumptions in the research process. Researchers conducting IE can use this framework to examine how their own perspectives and interactions influence the construction of knowledge about institutions.

In summary, social constructionism provides a theoretical lens to this study grounded in sociological theory (Berger & Luckmann, 1966; Prodinger & Turner, 2013) that enables the researcher to investigate how institutions are socially constructed through interactions, discursive practices, and power dynamics in IE. Adopting this perspective enhances understanding of the fluid, and socially contingent nature of institutional life, contributing to more nuanced analyses of institutional processes and dynamics.

1.7.1.3 Cultural identity theory

Cultural identity theory, as conceptualised by Collier and Thomas (1988), offers a valuable theoretical framework for conducting IE studies. This perspective facilitates an understanding of how individuals and groups shape and negotiate their identities within specific institutional contexts. The theory underscores the significance of cultural factors such as ethnicity, nationality, language, and socialisation experiences in the process of identity formation. Applied to institutional ethnography, cultural identity theory assists researchers in comprehending how identities are moulded within the distinct institutional settings under investigation.

Within institutions, identity negotiation is influenced by various organisational practices, norms, and discourses. Cultural identity theory aids in analysing how individuals navigate their identities within these institutional contexts, balancing personal identity with institutional roles and expectations (Collier and Thomas, 1988). Moreover, the theory complements IE by exploring how cultural practices within institutions such as rituals, language use, and power dynamics contribute to the ongoing process of identity formation and maintenance.

A central focus of cultural identity theory is the examination of power dynamics in identity construction. Understanding power within institutional contexts is crucial for discerning how certain identities are privileged or marginalised. Researchers can investigate how institutional structures either reinforce dominant cultural identities or challenge existing power hierarchies. By integrating cultural identity theory into their methodological approach, researchers can develop nuanced data collection methods, such as interviews and participant observations, to explore individuals' perceptions of identity within specific institutional settings.

Furthermore, cultural identity theory encourages a detailed analysis of discursive practices within institutions - how language and communication shape identities and influence self-identifications and interpersonal interactions. This analytical approach provides insights into how institutional discourses impact identity formation processes. Finally, by applying cultural identity theory, this study can inform recommendations for institutional change aimed at promoting inclusivity and responsiveness to diverse cultural identities. This theoretical framework enriches IE by shedding light on the complex interplay between cultural identities and institutional dynamics, thereby enhancing understanding of how individuals navigate identity within institutional contexts.

1.7.2 Contributing to the knowledge base of AMHP practice

Previous research examining AMHP work underscores their vital role in the mental health landscape, their intricate decision-making processes, the importance of collaboration, and the challenges they encounter. It has also been argued that their role is compromised by organisational systems and scarce resources, limiting their potential to meaningfully engage service-users and carers in less restrictive alternatives to compulsion and coercion. There is a lack of empirical research which looks specifically at the link between AMHP work processes, organisational systems and the disproportionate detention of Black service-users. This gap in the literature seems even more surprising, since as a discipline, social work is focused on promoting the importance of anti-discriminatory practice and social justice (Social Work England, 2019; British Association of Social Workers [BASW], 2015). This study uses IE to produce a “formal, empirically based scholarly” analysis of how social worker AMHPs experiences with processing MHA assessment are organised (Mykhalovskiy & McCoy, 2002, p. 20). I interrogate AMHPs for what they reveal about their work processes and decision-making as well as the broader implications for Black people subject to MHA assessments. Study findings provide an empirical basis for the development of race-conscious and culturally appropriate social work policies and practice which could inform future AMHP practice.

The disproportionate compulsory detention of people from Black ethnic groups occurs in an understudied and challenging context for mental health social work, despite policies and protocols that outline work processes in this context. Crucially, mental health professionals such as AMHPs bridge the gap between policy, implementation and practice. Therefore, their work processes could shed light on why previous

attempts to tackle ethnic inequalities through race equality training and policies to support equality in BME mental health, have had little, if any impact on closing Britain's ethnic health gap.

This will be the first known qualitative study in the UK to address this gap in the literature. Therefore, this study represents a substantial and original contribution to the knowledge base of AMHP practice and mental health social work. AMHPs undertake complex statutory decision-making processes, which balance caring and controlling functions. Examining how institutional and work processes impact their decision-making can provide valuable insights on the phenomenon of ethnic disproportionality in detention rates under the MHA. This information is crucial to service-users, carers, professionals and policy makers who seek to redress persistent disparities within Britain's mental health system. This is also critical to the implementation of solutions to tackle health inequalities.

1.8 The role of the AMHP in adult mental health services

The role of the Approved Social Worker (ASW) was introduced in the England and Wales Mental Health Act 1983, with the intention of bringing the social perspective to bear upon detention decisions and was supported by foremost exponents Gostin (1975) and the British Association of Social Workers (1977). When the MHA 1983 was amended in 2007 the 'Approved Social Worker' was renamed the 'Approved Mental Health Professional.'

AMHPs are skilled and experienced professionals, trained to undertake assessments under the MHA alongside doctors approved under S12 (2) MHA (Legislation.gov.uk, 2020). The 2007 amendment to the MHA, made a fundamental change to the role of mental health social workers (MHSWs) by extending the unique functions of the ASW to health professionals. Since 2007, registered mental health nurses, occupational therapists and psychologists have joined social workers as being eligible to train as AMHPs. However, in England social work remains the lead profession for AMHPs (Skills for Care, 2022; Davidson, et al., 2016).

AMHPs undertake an assessment and then consider whether an application for compulsory admission under the MHA is appropriate. This duty is enshrined in S13 (2) MHA. Particular details of the AMHPs' role are outlined in the Mental Health Act 1983: Code of Practice (DoH, 2015). AMHPs have overall responsibility for arranging and coordinating MHA assessments. This involves duties such as arranging for two doctors to assess and agree that a person meets the criteria for detention under the MHA. Part 2 of the MHA guides an MHA assessment. Admission under S2 MHA is for the purposes of assessment or assessment followed by treatment in hospital. The duration for S2 MHA is up to 28 days and cannot be renewed at the end of the 28-day period. Admission under S3 MHA is for the purposes of treatment in a hospital and the duration is up to 6 months, which can be renewed at the end of the first 6-month period, and yearly thereafter.

The MHA assessment involves inter-disciplinary decision-making. Ideally, assessments should be undertaken jointly (the AMHP plus the two doctors) as this ensures the person is not subject to repeated assessments and allows for a sharing of risk and professional judgement. An important element of the AMHP role is to “create a social counterweight to the medical viewpoint in the detention” (Bartlett and Sandland, 2014, p.259).

AMHPs also decide whether police presence is required and arrange conveyance of the person to a psychiatric hospital. Chapter 5 of the MHA Code of Practice (DoH, 2015) describes the AMHP’s legal obligation to attempt to identify the person’s nearest relative and/or consult other people who are known to the person and involved in their life. AMHPs are described by Brown (2013, p. 72) as “angst-ridden but strangely decisive” due to their responsibility for balancing the protection of both individual liberty and public safety, in complex and uncertain situations. Local authorities (LAs) have a statutory obligation to provide enough AMHPs to deliver an accessible service 24 hours a day, 365 days per year (DoH, 2015). However, although an AMHP acts on behalf of the LA, they must exercise their own judgement, based on social and medical evidence, and make the final autonomous decision on whether the person is detained.

In essence, the AMHP holds the balance of power in deciding after all circumstances of a case are considered, that detention in hospital is the most appropriate way of providing the care and medical treatment to meet the needs of the person. Figure 4 gives a broad overview of the pathway from the point an AMHP accepts a referral for a person with a mental health crisis to the point that an MHA assessment is completed. The role of the AMHP in detention decisions is further explored as part of this study’s literature review in chapter two of this thesis.

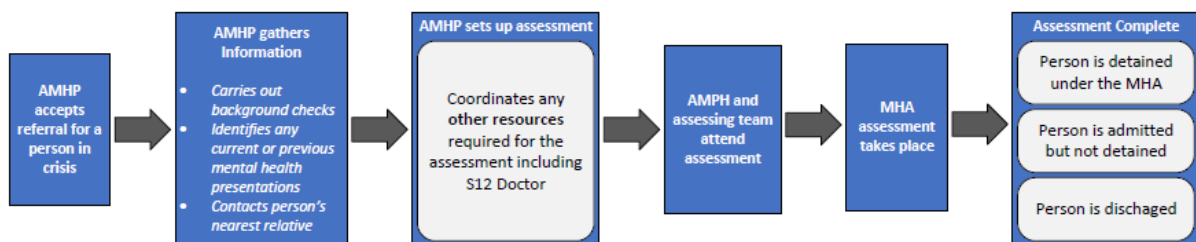


Figure 4. Pathway from the point an AMHP accepts a referral for a person with a mental health crisis to the point that an MHA assessment is completed

1.8.1 The unique role of social worker AMHPs

Social workers have a crucial part to play in improving mental health services and mental health outcomes for service-users (Allen, 2014). They bring a distinctive social and rights-based perspective to their work. Their advanced relationship-based skills and their focus on personalisation and recovery, can support people to make positive, self-directed change. Social workers are trained to work in partnership with people using services, their families and carers, to encourage involvement and collaborative solutions (Allen, 2014; gov.uk, 2019; BASW, 2020). Social workers also manage some of the most challenging and complex risks for individuals and society and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the AMHP workforce (Skills for Care, 2022) hence the reason social worker AMHPs were chosen as this study's informants.

Social worker AMHPs working in statutory mental health services in England and Wales provide a vital counterbalancing view to clinical models of illness and disorder and where this is done well, can have a powerful impact on NHS culture and practice. It is therefore necessary to understand and explore the wider context in which social worker AMHPs experience and work within in order to tackle the issue of disproportionality in rates of compulsory detention for Black people detained under the MHA. It is also important to explore where the unique contribution of social worker AMHPs currently lies in the field of contemporary mental health social work. In doing this, it is important to understand the difficulties and barriers social worker AMHPs face in their day-to-day practice.

Understanding these challenges may provide social work professional bodies and employers of social workers with a better opportunity to help address the concerns of social workers regarding the delivery of a better, more equitable service. All professionals, including social workers, in both their statutory duties and non-statutory practice, should always be aware of perpetuating practice that contributes to these inequalities. Hence, practitioners should remain conscious of the deep-rooted attitudes and relations of power that are built into the fabric of the systems in which practice is conducted.

1.9 Purpose of the study

This study's purpose is to form a narrative that describes the systemic ways in which the role of social worker AMHPs conducting sectioning under the MHA is structured and operationalised. In doing so, it will examine its specific impact on Black service-users and any challenges this poses on the AMHPs' ability to provide independent decisions seeking the least restrictive alternative and bringing a social perspective to bear on their decision.

As previously mentioned, policies and procedures guide the professional practices of social worker AMHPs when carrying out their statutory duties such as conducting MHA assessments. However, where

policies and procedures exist, they risk glossing over the nuances and details of what actually happens in context. Indeed, many problems within mental health social work are tacit, hidden from view to onlookers and poorly understood by practitioners who may sense that something is amiss but struggle to articulate the nature of their concerns (Goemans, 2012). Understanding the nature of this phenomenon is crucial to addressing the ethnic disparities in compulsory detention rates under the MHA. Awareness of the actualities of AMHPs' work processes is also crucial to the systems within mental health and social services.

1.10 Theoretical framework and research questions

1.10.1 Research questions

The underlying aims of this study are: (a) to use data from in-depth semi-structured interviews with social worker AMHPs, to examine how MHA assessments are organised and (b) identify any disjunctures within the MHA assessment process which may impact AMHPs' decision to detain Black service-users and/or serve as a diversion away from detention.

This PhD research will apply institutional ethnography (IE) (Smith, 2005; 2006), as a social theory and method of enquiry to answer the following research questions:

- i. *To what extent are the accounts of social worker AMHPs "actual" experiences of coordinating MHA assessments with Black service-users representative of the "ideological" work of AMHPs (are some things unaccounted for?)*
- ii. *When applying the least restrictive option and bringing the social perspective to bear on their decision, what factors influence AMHPs' consideration of whether to detain an individual under the MHA? Are there specific implications for Black service-users?*

1.11 Why is this study important to me?

1.11.1 My previous training and research

During my social work training, we were taught about mental health social work and the statutory role of the AMHP within mental health services, as well as the legal and socio-political contexts. Lectures emphasised the need for social workers to maintain a broad social view of mental health problems especially in regard to concerns about discriminatory practices, civil rights and social justice. We were encouraged to reflect on the impact of social inequalities, specifically in relation to marginalised groups and racialised communities. To support our reflections, we discussed the phenomenon of overrepresentation of BME people in the more coercive parts of the mental health system such as involuntary inpatient psychiatric care and underrepresentation in voluntary primary care services.

Overwhelmingly, the literature, statistics and lectures depicted a broken system in which people from BME backgrounds, in particular young Black men, were disadvantaged by the incumbent mental health system, services, practices and policies. Learning about the disparities within the mental health system and the specific disadvantages faced by people who looked like me, created a feeling of personal resonance that I was deeply disturbed by. As a social work student, my training was underpinned by anti-oppressive and anti-discriminatory practice and the pursuit of social change for marginalised and oppressed individuals and groups of people. This is integral to the ethics and values registered social workers are expected to uphold such as promoting the rights, strengths and wellbeing of people families and communities. These expected standards are summarised by Social Work England, the professional regulator for social workers in England:

“Social workers understand the multiple and intersecting oppressions and disadvantages that impact people, families and communities. They use their professional power in a positive way with their employer and other professionals to uphold standards and decisions and to challenge structures. They pursue positive change, particularly with and on behalf of people, or groups of people, who are vulnerable or facing oppression. They engage in action and dialogue to shine a light on the structures in society that create and perpetuate injustice. Social workers strive for equitable access to information, services, resources, and opportunities. Wherever possible, they work towards strengthening communities, respect ethnic and cultural diversity and value difference.” (Social Work England, 2019)

I chose adult mental health as my final year dissertation topic and specialist module. My Bachelor of Arts (BA) Social Work dissertation was a systematic review which addressed the research question: *“What is known about barriers to accessing adult mental health services for BME groups in England?”* Objectives included determining differences in barriers to access between BME men and women, specific BME groups as well as collective barriers experienced across BME groups. The systematic review identified a diverse body of literature that examined barriers to accessing mental health services for BME groups. Thematic analysis of 14 studies revealed barriers to BME people accessing mental health services such as discrimination, stigma and mistrust of services, professionals’ lack of understanding of cultural and faith issues and lack of talking therapies.

Findings revealed a “web” of relationships that potentially had reciprocal links between possible combinations of barriers. There were four domains identified as barriers to BME groups accessing mental health services namely: cultural, structural, knowledge/educational and material, these domains were underpinned by thematic findings (Figure 5). These themes do not operate in isolation, instead there is interplay amongst all of them, and on their own or combined can create barriers to accessing mental health services for BME people (Aleong, 2018). I was awarded the University of York’s Department of Social Policy and Social Work Department prize for “Best Social Work Dissertation 2018.” This gave me the

impetus to build my research profile by disseminating my research findings. Following peer review of an abstract of my study's findings, I was accepted for a poster presentation at the 9th International Conference on Social Work in Health and Mental Health in 2019. I then planned to expand my engagement in further research addressing ethnic inequalities in mental health services by undertaking a master's degree in social research.

My previous research into ethnic inequalities in mental health care highlighted that social research which focused on AMHP practice was a relatively underdeveloped area. This is because historically, bio-medical approaches and interpretations of mental health have dominated mental health research and practice. People have now begun to recognise the social aspects of mental illness more so in the wake of the COVID-19 pandemic. Additionally, within increasingly interdisciplinary mental health teams, social worker AMHPs are uniquely positioned to assert perspectives from the social model of mental health as professionals with a social services background. Social worker AMHPs therefore play an important role in contemporary interdisciplinary mental health teams.

Building on the findings of my BA, my Master of Arts (MA) Social Research dissertation was a qualitative study which sought the perspectives of social worker AMHPs to find out: "*How can mental health professionals mitigate the overrepresentation of BME people compulsory detained under the MHA?*" (Aleong, 2019). Ten social worker AMHPs were purposively selected from two local authorities in the North of England to participate in this study which used in-depth interviews and a focus group to collect data. Grounded theory was used during the analysis of data, which consisted of participants' verbatim quotations. This study offered a focused insight into the phenomenon of overrepresentation from the perspective of social worker AMHPs who can be understood as occupying a socio-medical-judicial perspective. Thematic analysis revealed seven interrelating factors, which AMHPs implicated in the disproportionate compulsory detention of BME people under the MHA, these were:

- i. Emotional labour (stress of engaging with people experiencing mental distress)
- ii. Limited scope applying MHA in practice (dichotomous: detention or non-detention)
- iii. Poor socio-economic circumstances of the person subject to MHA assessment
- iv. Lack of resources (voluntary in-patient psychiatric hospital beds and crisis care)
- v. Tensions with interdisciplinary working (medical vs. social models of mental health)
- vi. Discrimination/ Institutional racism (racial stereotyping of BME people)
- vii. Culture of risk aversion in mental health services.

The study concluded that mitigating over-representation of BME people involuntarily detained under the MHA calls for a collaborative multidisciplinary and multi-agency approach involving regulatory bodies and service providers outside the field of health and social care, such as the criminal justice and

educational systems. AMHPs could play a significant role in this process however, there needs to be fundamental improvements in the socio-economic conditions of BME people, as well as a culture shift within services with greater efforts behind implementing active government policies and programmes of mental health promotion aimed at BME people (Aleong, 2019).

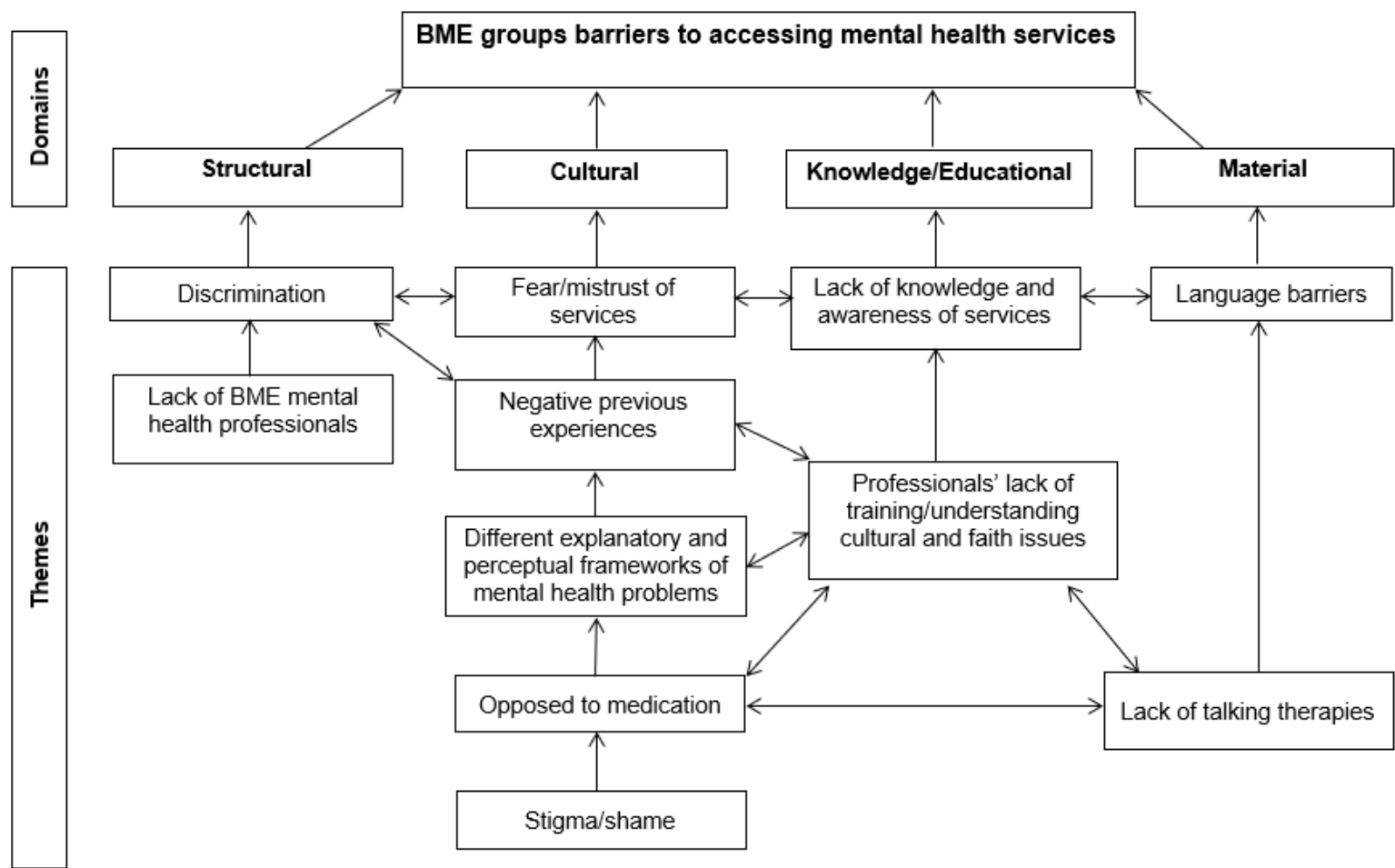


Figure 5. Thematic diagram of barriers to BME groups accessing mental health services in England

Source: Aleong, 2018

1.11.2 Developing this PhD research project

Areas of practice with marginalised populations should require social work to consider its role in the processes leading to the disproportionate involuntary detention of Black service-users under the MHA. The vast majority of the AMHP workforce (94 percent) are social workers hence, it can be argued that social worker AMHPs are directly involved in the processes which lead to the disproportionate detention of Black service-users, as they make the final decision as to whether someone should be detained or not. This is also why social worker AMHPs were considered the most appropriate group to interview for this research. Conducting MHA assessments is one of the many elements of the AMHP's role and I acknowledge that AMHPs alone cannot be held accountable for the myriad of issues that contribute to ethnic inequalities in treatment and outcomes for Black people. However, AMHPs can play an important role in this process. Denzin and Lincoln (2011) explain that through qualitative research we seek answers to questions that emphasise how social experience is created and given meaning. Crucially, mental health professionals such as social worker AMHPs bridge the gap between policy, implementation and practice, and could shed light on why previous attempts by successive governments to tackle these inequalities through numerous commissioned reports, legislative reviews and policy initiatives have had little, if any, impact on closing Britain's ethnic health gap. By examining the sources of disproportionality this study seeks to understand what drives ethnic disparities in detention rates, including how inequalities enter the mental health system – as a social worker, these issues are of central importance to me.

The differential treatment of Black people coming into contact with mental health services has resulted in consistently poor outcomes for this group – a situation that seems unchanging. Even during the COVID-19 pandemic, ethnic inequalities were clear, as it disproportionately devastated Minority Ethnic groups in Britain, from severity of infection and scale, to the loss of life (Public Health England, 2020). Further, tragedies such as the 1998 death of an Afro-Caribbean man named Rocky Bennett, who died after being forcibly restrained by several nurses as a psychiatric patient (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) and the two other deaths of Black men receiving mental health services (RAW.Org, 2010) motivated me to further my research in this area.

For my PhD, I sought to build on the findings of my previous research and further investigate the possible reasons for the longstanding disproportionate compulsory detention of Black people under the MHA. I am interested in conducting empirical, qualitative social research that carries the possibility of being relevant to mental health social work policy and practice. Could findings from an IE aimed at explicating how the work of informants (AMHPs) is organised in relation the MHA assessments and compulsory detention of Black people add to the knowledge base of mental health social work and beyond? My intention is to engage in research aimed at promoting anti-oppressive practice for new generations of social workers. I am interested in deconstructing the systemic structures and processes that create and perpetuate overrepresentation of Black people within the mental health system. Importantly, I was drawn to the role

social work can play in this process. My motivation, research questions, and research methods are therefore all rooted in this study's emancipatory possibilities.

This is the first study of its kind to investigate how the work processes involved in MHA assessment impact AMHP decision-making with Black service-users. This research reveals how IE's emancipatory value is linked to identifying and examining disjunctures, which can be described as anomalies, discrepancies or disconnections between what is understood to be happening versus what is actually being experienced (Smith, 2005; De Vault, 2006). A key tenet of IE is that institutions and organisational systems play an important role in the coordination of information, resource allocation, access to services, and every day "doings" of people they aim to serve (Campbell & Gregor, 2008; Smith, 1999, 2005). By focusing on institutional practices, IE incorporates and pays particular attention to individuals, organisations, institutions, and relevant texts, including manuals, policies, procedures, and memos as part of the analysis (Mykhalovskiy, 2003; Smith 2005; 2006; Sinding, 2010). The ethnographic component reflects the way in which researchers start by exploring the everyday experiences of a particular group of people (in this study social worker AMHPs) piecing how their social world is put together by the idea of work – defined by actions that take time, effort and intent (Smith, 2006). IE departs from the interest in generating theory, but rather aims to produce evidence-based research that maps both human and textual/policy/institutional relations - in other words, to trace the relationships and kinds of communication that is facilitated between people, texts, and relevant institutions (Mykhalovskiy, 2003; Smith 2005; 2006). Practically and materially speaking, I was drawn to a method of inquiry that was invested in multiple forms of data collection, including interviews, observations, and any relevant forms of text.

1.12 My ontological position

I position myself as a critical realist (Houston, 2010; Moren & Blom, 2003; Oliver, 2012, Bhaskar, 2015). I see people as active in constructing their own world, while also constrained and shaped by structures that have real effects (Sayer, 2010). Critical realist research accepts an objective reality lies beyond ideas and concepts, potentially explaining why particular social problems arise and generating practical and emancipatory outcomes. It aims to explain rather than describe phenomena in a way that leads into "consideration of right conduct and the good life" (Houston, 2010, p. 74). These precepts align with social work's central tension of care and control, vision of emancipation, and focus on marginalised groups (Oliver, 2012). Critical realism as a philosophy of science to underpin research potentially meets the requirements for evidence-based social work practice, the role of individual agency and social structure, theory building, and the pursuit of practical emancipatory goals (Oliver, 2012; Archer, 1995). This also points to the understanding of social constructionism inherent in IE (Prodinger & Turner, 2013).

1.13 Thesis structure

This thesis presented in ten chapters, consists of the following:

Chapter Two of this thesis is a literature review which provides a cohesive summary of existing knowledge in relation to: the factors that influence AMHP decision-making; ethnic disparities in the British mental health system and the socioeconomic determinants of mental health with its possible manifestations within the field of social work.

Chapter Three provides an overview of the study's research design and methodology. The ontological and epistemological underpinnings along with the key conceptualisations and terms in IE as a method of enquiry are discussed.

Chapter Four explains the framework for data collection and analysis. It outlines the steps I took before entering the field; describes the recruitment of informants and my movement into and across field sites. Some of the challenges that I experienced during the fieldwork and how I addressed these are explained. The process of ethical approval of this study is reviewed along with thoughts on how and why IE was a useful research strategy for accomplishing the aims of this project.

Chapters Five to Eight are the core chapters of this thesis. Together, these chapters are developed into a kishōtenketsu with four themed manuscripts which represent the findings and themes that emerged from the data. Specifically, these chapters address the study's research questions and discuss the ways through which AMHP work is operationalised on the front-line. It is the ethnographic heart of the thesis. It details the experiences and activities of informants during the different phases of the MHA assessment and post assessment requirements.

Chapter Nine provides an integrated discussion of the findings within the core chapters and outlines this thesis' contribution to the knowledge base of social work policy and AMHP practice.

Chapter Ten is the final chapter of this thesis. It outlines the implications of this study's findings for AMHP policy and practice and suggestions for future research. I provide a reflexive review of my experiences throughout the doctoral process and end with a conclusion.

Chapter 2. Literature Review

2.1 Considering the literature

In this chapter, I contextualise the study and describe the process involved in my review of the relevant literature. The strategy for reviewing the literature is set out and is followed by a critical evaluation of this study's academic discourse. The review of the literature was a reflexive process which extended from 2018 to mid-2022.

2.1.1 Exploratory work

Before the commencement of my PhD, and as part of my funding application to the Economic and Social Research Council (ESRC), White Rose Doctoral Training Partnership (WRDTP) in 2018, I was required to prepare and defend my research proposal for this study. I initiated numerous exploratory inquiries into ethnic disparities in mental health outcomes for Black people and the role of social worker AMHPs in sectioning processes under the MHA. I conducted a review of the literature during the preparation of my research proposal. My interest in ethnic disproportionality in detention rates under the MHA piqued through my consumption of academic literature. In 2018 during my MA in social research I sought the perspectives of social worker AMHPs to answer the research question: *How can mental health professionals mitigate the overrepresentation of BME people compulsory detained under the MHA?* I was familiar with some of the literature which engaged specifically with the overrepresentation of Black people in mental health services. However, I was not aware of a body of work which examined the work of AMHPs in relation to the disproportionate sectioning of Black people. To address this, I undertook a gradual transparent and structured approach to my literature search, continually refining over the duration of my research. In that regard, my literature search was not systematic as my filtering and search strategies did not follow a predefined protocol and were informed by my findings. The purpose of my search was not simply an exercise to find informative literature, instead I actively looked for associations and connections between AMHPs, Black or Minority Ethnic service-users, mental health and detentions under the MHA. I used the literature to form an understanding of the concept of “ethnic disproportionality” in detention rates its relationships, actors, processes and dilemmas, to bring some context to the widely used term.

2.2 Early database searching

During 2018, I investigated the UK context for research on AMHP decision-making, ethnic disparities in mental health and the socioeconomic determinants of mental health. Later on, I also looked at international academic and grey literatures where it helped to evidence wider trends or where limited evidence existed in the UK context. Literature from scholars in other regions outside the UK helped to inform this study's objectives however, before attempting to achieve a broader synthesis I focussed my attention on extant literature in the UK context. Reasons for this are the legislative and service delivery variations as well as social context between the UK and other countries in relation to mental health services (Campbell, 2010).

Details of these searches are as follows:

2.2.1 UK

- i. A search of the electronic database was separated with the criteria: “title,” “topic” “keywords” and “search history” functions of various databases were used to manipulate search terms. This search was replicated across the following databases: Web of Science, Scopus, Social Care Online and ASSIA. Keywords included UK, Black, Black British, Black and Minority Ethnic, African-Caribbean, BME, BAME, mental health, ethnic disparities, detention, Mental Health Act, approved mental health professional, AMHP, social work. Due to the limited frequency of relevant articles and to assist with improving the quality of the searches, the search terms and parameters were refined for example, geographical location and times frames.
- ii. Hand-searching at the University of York Library and manual scoping for studies were done to ensure a thorough search was conducted and all the data was captured (Blaxter et al., 2001).
- iii. Abstracts were reviewed and screened based on relevance to Black or Minority Ethnic, African or African Caribbean in the context of mental health in the UK. Papers that that did not focus on ethnic disparities, or the role of mental health professionals were excluded together with papers such as commentaries and editorials that did not describe a research study.
- iv. A search of grey literature was conducted. The term ‘grey literature’ refers to reports published outside of traditional commercial publishing (Higgins et al., 2023). This involved accessing non-traditional sources of information that are not typically published in academic journals or books. This included reports, theses, conference proceedings and government publications. The search engine Google Scholar, and University of York repositories such as Bielefeld Academic Search Engine (BASE); Health Management Information Consortium (HMIC), King’s Fund Database, Electronic Theses Online Service (EThOS) to locate relevant grey literature sources. Search techniques, including Boolean operators and filters, helped refine search results. Government websites such as the Department for Health and Social Care were also explored. Throughout the process, the credibility and relevance of identified grey literature sources were evaluated. Integrating grey literature with traditional academic sources, facilitated a comprehensive understanding of the research topic, enriching the depth and breadth of the literature review.
- v. Key references were identified from bibliographies and followed up to identify any papers not found in the original search. Review of full-text articles were limited to those available through the University of York subscriptions and those published with open access on the Internet. The “related article” and “cited by” feature were also used to trace references in most relevant articles.

- vi. Wallace and Wray's (2011) evaluation tool was used to appraise papers. This approach allowed for a systematic method of undertaking the literature review without adhering to the official criteria and hierarchy of evidence required by the Cochrane (Higgins et al., 2023) and Campbell (Littell & White, 2018) methods of systematic reviews which would have excluded most relevant studies (Sharland, 2012).

2.2.2 International

- vii. A second phase of searching (similar to the criteria outlined in i to vi) was conducted. Keywords included: mental health, mental illness, detention, Africa, Caribbean, African- Caribbean, Black African, Black Caribbean, America, Minority Ethnic, ethnic disparities, racial disparities.

A review of the grey literature in early 2019 piqued my interest in the link between ethnic disparities in socioeconomic and mental health indices, mental health outcomes and access to mental health services. I was also interested in factors which contributed to the ethnic disparities in socioeconomic and mental health indices. This gave me some context to understand the historical and structural contributors to ethnic disparities within the mental health system in England.

2.3 Inclusion and exclusion criteria for literature review

2.3.1 Inclusion criteria:

1. Studies published in peer-reviewed journals or reputable academic sources.
2. Literature that specifically examines the experiences, perspectives, or practices of mental health professionals, social workers, AMHPs and ASWs in relation to the disproportionate detention of Black and Minority Ethnic individuals under the MHA.
3. Articles or research papers that focus on the intersection of mental health law, social work practice, and ethnic disparities in compulsory detention under the MHA.
4. Literature that discusses the role of AMHPs and mental health professionals in assessing and coordinating the care of individuals under the MHA, particularly concerning issues of cultural competence, discrimination, and human rights.
5. Research studies or qualitative analyses that explore the factors contributing to the overrepresentation of BME individuals detained under the MHA, as perceived or experienced by AMHPs or ASWs.
6. Publications that provide insights into the challenges, barriers, or ethical dilemmas faced by AMHPs when conducting MHA assessments and /or decision-making involving BME individuals.

2.3.2 Exclusion criteria:

1. Non-academic sources, such as opinion pieces, blog posts, or news articles.
2. Studies that do not specifically focus on the experiences or perspectives of AMHPs or ASWs in relation to decision-making the detention of individuals under the MHA.
3. Literature that primarily examines broader mental health issues without specific reference to ethnic disparities in detention or the role of social workers and AMHPs.
4. Publications that do not address the intersection of race, ethnicity, and mental health law within the context of social work or AMHP practice.
5. Studies that are outdated or not reflective of current practices and policies related to detention under the MHA.
6. Research that lacks methodological rigour or credibility, such as anecdotal reports.

2.3.3 Evaluation tool

This study adopted Wallace and Wray's (2011) evaluation tool for determining the suitability of a text for inclusion in the literature review. The Wallace and Wray (2011) tool, also known as the 'suitability framework,' is a systematic approach used to assess the relevance and quality of literature for inclusion in a literature review. This tool involves a structured process of evaluating each potential source against specific criteria to determine its suitability for addressing the research questions or objectives of the study. The following are the steps which demonstrate how the tool was used as a structured method for assessing the relevance and quality of literature intended for inclusion in this study's literature review:

1. Identifying relevant criteria: The first step involved identifying key criteria for determining the suitability of literature for inclusion.
2. Applying the criteria: Each potential source identified for the literature review was evaluated against the predetermined criteria. This evaluation was conducted using Wallace and Wray (2011) checklist to systematically assess the literature.
3. Ranking: Based on the assessment of each criterion, the literature was ranked to indicate its level of suitability. Ranks were assigned categorically (high, medium, low) based on how well the source met the specified inclusion criteria.
4. Decision-making process: The rankings obtained for each criterion were then used to inform decisions about whether to include or exclude the literature from the review. Sources that meet the required criteria were prioritised for inclusion.

The Wallace and Wray (2011) tool emphasises rigour and transparency in the literature selection process by providing a clear and systematic method for evaluating literature. This helped ensure that only high-quality, relevant sources were included in the literature review, enhancing the credibility and robustness of the research findings. This valuable framework was used to critically assess and select literature that aligns with the objectives and scope of this study. Applying this systematic approach, enhanced the quality and comprehensiveness of the literature review, ultimately contributing to the rigour and validity of the research outcomes.

Overall, the inclusion and exclusion criteria for literature selection aimed to ensure that the review focused on relevant, high-quality academic sources that directly contribute to understanding the factors that affect AMHP decision-making.

2.4 Later database searching

From 2019 to mid-2022, I updated and expanded the literature search using the themes found in earlier reviews of the literature. Thematic analysis was used to seek patterns in these data (Braun & Clarke, 2006). This was a necessarily interpretive process that was likely to have been influenced by my training and experience as a social worker and findings from my previous research involving AMHPs as research participants. The themes that emerged from the early and later literature reviews are presented in Table 1. The literature highlighted that scholarly attention to the issues of overrepresentation of Black people within coercive parts of the mental health system began in the 1980's and ran through to the present time in the 2020's. The literature relating to ASW and AMHP decision-making was broad, however, my review of the literature revealed my proposed inquiry was original since there were few sources which examined AMHPs' accounts of front-line experiences of conducting MHA assessments and decision-making impacting people from Black and/or Minority Ethnic groups.

Table 1. Themes from reviews of the literature

<p>Factors that influence AMHP decision to detain</p> <ul style="list-style-type: none">• Professional Accountability: Buckland, 2016; O'Hare et al., 2013; Quirk et al., 2003; Skinner, 2006; Gregor, 2010; Kinney; 2009; Fistein et al., 2016; Glover-Thomas, 2018.• Assessment of Risk: Quirk et al., 2003; Glover-Thomas, 2011; Sheppard, 1993; O'Hare et al. 2013; Buckland, 2016; Hall, 2017; Abbott, 2018; Peay, 2003; Gale (2016).• Emotional Labour: Everett Hughes, 1971; Emerson and Pollner, 1976; Morriss, 2016; Wharton 2009; Nacro, 2017; Vicary et al., 2019; Leah, 2022; Carpenter et al., 2003; Haynes, 1990;
--

Gregor, 2010; Dwyer, 2012; Stone, 2017; Thompson, 2003; Peay, 2003, Abbott, 2018; Quirk, 2007; Kinney, 2009.

- Intuition: Dwyer, 2012; Buckland, 2016; Morriss, 2016; Stone, 2017; Kinney, 2009; Glover-Thomas, 2011; Skinner, 2006; Vicary, 2017; Williams, Alderson et al., 2002; MacLeod & Stadnyk, 2015.
- Alternatives to Detention: Quirk et al., 2003; Quirk 2007; Aleong, 2018; Kinney, 2009; Campbell et al., 2001; Manteklow et al., 2002; Hall, 2017; Haynes, 1990; Buckland, 2016; Stone, 2017; Glover-Thomas, 2018; Dwyer, 2012; Fistein et al., 2016; Thompson, 1997; Abbott, 2018.

Ethnic Disparities & Black Mental Health:

- Overrepresented in their local detained populations and more likely to be detained under the MHA than White groups: (Wall et al., 1999; Fernando & Keating, 2009; Eaton & Harrison, 2000; Gajwani et al., 2016; Nazroo, 1997; Bhui et al., 2002; Keating et al., 2002; Nacro, 2007; Singh et al., 2007; Anderson et al., 2014; Audini & Lelliott, 2000, ; Edge & MacKian, 2010; Rabie & Smith, 2013; Furminger & Webber, 2009; Bhui et al., 2003).
- Higher rates of Community Treatment Order (CTO) use and are the highest rate of detained people subject to repeated detention: (Singh et al., 1983; Bhui et al., 2003; Lammy, 2017).
- Overrepresented in the most restrictive parts of the mental health system such as inpatient and forensic services than other ethnic groups: (Glover & Evison, 2009; McLean et al., 2003; Edge & MacKian, 2010, Faulkner, 2014; Rabie & Smith 2014; Islam et al., 2015 and Memon et al., 2016).
- Strong correlation between social disadvantage, ethnicity and compulsory admission to psychiatric hospital: (Hatfield et al., 1997; Modood, et al., 1997; Bhui et al., 2003; Erens, Primatesta, & Prior, 2001; Manteklow et al., 2002; Hatfield, 2008); Webber & Huxley, 2004, Thornicroft, 1991; Jarman et al., 1992; Campbell et al 2001; Manteklow et al 2002; Campbell and Davidson 2009). Hatfield et al., 1997).
- Concept of “ethnic schizophrenia” in the UK that is Black incidence rate of schizophrenia shifting in favour of factors of social alienation and racism experienced by Black people in the UK, and to misdiagnosis by White British psychiatrists: (Boydell et al., 2001; Mallett et al., 2002; Whitley et al., 2006; Hickling, 2005).

- Social determinants of mental health shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live: (WHO, 2014; Elliot, 2016; Marmot et al., 2020; Kenway & Palmer, 2007; Strand, 2014; Kiernan & Mensah, 2011; Mandara et al., 2009; Johnson et al., 2006; Catalan et al., 2011, McIntosh, 1988, Blum, 2008).
- Police officers prone to associating Black people with risk factors, Black people are more likely to be detained by police under S136 MHA and taken to a “place of safety”– often a psychiatric hospital – thereby opening that channel into the psychiatric services: (Docking, 2009; Shiner et al., 2022; Wunsch et al., 2016; Lammy, 2017).
- Racial stereotyping and discrimination against Black men are implicated in perceptions by MH professionals of them being “Big, Black, and Dangerous”: (Prins et al., 1993, Monk, 2015; Wilson, 2017; Shiner et al., 2018; Shankley & Williams, 2020; White et al., 2020).
- More punitive and restrictive forms of mental health treatment are meted out to BME groups, which is directly linked to raised rates of involuntary detention under the MHA: (Memon et al., 2012; Memon et al., 2016; Edge and MacKian, 2010; Keating et al., 2002).
- Correlation between experience of trauma and historic disadvantage, racism and mental health problems such as psychosis and depression: (Wallace, Nazroo J. & Becares, 2016; Bhui et al., 2018; Williams, 2018; Gibbons et al. 2012; Williams & Williams-Morris, 2000; Sewell, 2012; Bhugra & Ayonrinde, 2001; Hammack, 2003; Mallet et al., 2002; Hickling, 2005, 2020; Sewell, 2012; Rabie & Smith, 2013; Islam et al., 2015; Helm et al., 2010; Wallace et al., 2016; Alleyne, 2017; Sue, et al., 2007; Carlson, 1997; Lashley, 1986; Paul, 1997; Sutherland, 2006; Williams, 1986; Kyriakides & Virdie, 2003; Tyler et al., 2022)

A third and final phase of searching similar to the criteria outlined in i to vi was undertaken. Originally a publication year of 2008 was set for the search. This is because the amendment to the MHA in 2007 which was implemented in 2008, meant that the role of Mental Health Social Workers (MHSWs) had changed significantly by extending the role and functions of the ASW to other eligible health professionals such as nurses, occupational therapists or psychologists, creating the role of the AMHP. By restricting the search year to 2008, few relevant studies were found therefore, I extended the search to papers published in English between 1983 and the end of June 2022. Limiting the language was a pragmatic choice, whilst the date restriction corresponds with contemporary mental health legislation.

An example of some of the keywords that were used as part of the database searches were: AMHP, approved mental health professional, approved social worker, ASW, mental health social worker, MHSW, MHA, Mental Health Act, detention, sectioning, institutional ethnography, social work, decision-making, Black, Minority Ethnic, BME, BAME, African, African-Caribbean, Black British. The results of databases searched is tabulated below.

Table 2. Results of databases searched

Database	Relevant to subject of thesis
Assia	75
Scopus	56
Web of Science	90
Social Care online	126
Google Scholar	23
Total	370
Total relevant after review and removal of duplicates	122

2.5 Review of the literature

2.5.1 What factors influence AMHPs' decision to detain?

The literature relating to AMHP decision-making is diverse and includes aspects of AMHP decision-making that are peripheral to the focus of this study. There is a lack of literature which specifically examines AMHP detention-decisions in the context of the ethnic disproportionality. Thus, AMHP decision-making is discussed more broadly with differences in context making comparisons between the literature more interpretive. Applicable texts in this literature review include published empirical studies, empirical studies as doctoral theses, empirical studies published as books, and theory papers.

Previous studies have examined the work of AMHPs, shedding light on their roles, challenges, and contributions within the field of mental health. These studies have collectively revealed that AMHPs play a critical role in assessing individuals' mental health needs, determining the necessity for compulsory treatment, and coordinating interventions. They navigate complex legal frameworks, clinical considerations and ethical dilemmas to make informed decisions.

Research exploring AMHP decision-making emphasise their responsibility to safeguard individuals' rights while considering their best interests. Studies have highlighted the collaborative nature of AMHP work,

involving interactions with various people and institutions, for example, service-users, families, psychiatrists, nurses, doctors, conveyance teams, ambulance teams, police and social workers. Additionally, studies have identified challenges faced by AMHPs, such as coercion, burn out, lack of resources, dealing with resistance from service users and professionals.

In this review of the literature, accountability, assessment of risk, intuition, alternatives to detention and emotional labour were identified as the main themes with the concept of morality being a common thread, intertwined across all themes. These five themes will be discussed in turn in the sections that follow.

2.6 Accountability

Using grounded theory, Skinner (2006) sought to understand the experience of ASWs, psychiatrists and nurse practitioners undertaking MHA assessments. Of the eleven research participants, seven were ASWs. Skinner (2006) found that professional liability was a significant factor in detention decision-making.

Kinney (2009) explored the ethical implications of the processes which lead to detention. Findings revealed that when faced with two medical recommendations for detention, the AMHP's autonomy is over-ruled and relinquished to concerns about accountability for risk-taking (Kinney, 2009). Crucially, Kinney (2009) highlights the ethical dilemma involved in AMHP decision-making as whilst being accountable for risk-taking, AMHPs had virtually little power to influence less coercive approaches to risk-taking which inevitably lead to moral conflict (Kinney, 2009). Findings indicate where alternatives to compulsion are not available, professional accountability and risk may present ethical compromise.

Quirk et al. (2003) explored non-clinical and extra-legal influences on professionals' decisions about compulsory admission to psychiatric hospital. They found that support from colleagues and peers reduces the likelihood of detention. Gregor (2010) found ASWs experienced stress from their responsibility in being required to make detention decisions. Both Gregor (2010) and Quirk et al. (2003) found that with regard to making detention decisions, ASWs valued working in a supportive team. A "blame culture" within organisations was implicated by Quirk et al. (2003, p. 128) to ASWs favouring a detention decision in order to avoid criticism. Crucially, these findings highlight how organisational culture may influence AMHPs' detention decisions through the AMHP's perception of accountability (whether genuine or imagined).

Fistein et al. (2016) adopted a mixed methods approach to their study using IE and individual narrative interviews. They observed discussions between AMHPs and medical practitioners following MHA assessments and found that practitioners feared accountability for a person's future behaviour (Fistein et al. 2016). They combined this alongside individual narrative interviews with those practitioners using a biographical narrative interpretive methodology. Their study involved a limited number of AMHP participants. While five AMHPs were involved in the observational component, only one AMHP was interviewed individually. Nevertheless, this finding is consistent with wider research. In a later paper,

Glover-Thomas (2018) theorised that a fear of adverse consequences influences detention decisions. Together, these findings suggest notions of moral and ethical conflict underpin risk taking and accountability in detention decision.

O'Hare et al. (2013) explored social work views about the context of risk, decision-making and compulsory intervention across the three jurisdictions (England, Wales and Northern Ireland) using survey vignettes. O'Hare et al. (2013) hypothesised a risk averse climate where future risks are overestimated. Buckland (2016) supported this finding when she explored the processes involved when AMHPs use compulsory powers, focusing on contextual processes, including how individual values, interpretations of the MHA and contemporary societal discourses were described by participants. Buckland (2016) reported that all study participants linked public discourses on risk to defensive risk averse practice due to personal accountability.

2.7 Assessment of risk

Quirk et al. (2003) explored first-hand, the practice of ASW through a participant-observation fieldwork study. The study took place over fourteen months with twenty assessments being observed in five teams across two London boroughs. Grounded theory was used to analyse the data. Quirk et al. (2003) found that a greater knowledge of the person being subjected to assessment raised ASWs' risk tolerance level. It was also observed that this knowledge of the person being assessed extended beyond mere information held on case notes to a more personal, holistic understanding of the person based on a relationship the ASW had built with them. These findings suggest that AMHP's form situated risk constructions by morally engaging with the person being assessed.

Sheppard (1990) conducted research over twelve months which examined 120 referrals and included semi-structured interviews with nine ASWs. Sheppard (1990) adopted a risk analysis methodology with the aim of assessing the implicit risk criteria for detention used by ASWs. Findings highlighted the interpretive nature of risk assessment with differing thresholds by which detention may be justified. These individual decisions suggest that the notion of risk may be a personal decision since not all people with the same professional and training made the same decisions. Peay (2003) explored differences in perceptions of risk and decision-making between participants from different mental health professional backgrounds in the context of compulsory mental health law. Peay (2003) examined how forty psychiatrists and forty ASWs made detention decisions together, adopting a vignette methodology using a hypothetical case video and notes. Like Sheppard (1990), Peay (2003) found that despite being provided with written information about the person being assessed, ASWs generally desired a more personal connection with the person prior to making a decision about detention, thereby introducing a moral dimension to the decision-making process.

Stone (2017) undertook a vignette study adopting the same case video used by Peay (2003). He conducted semi-structured interviews with ten social worker AMHPs and ten nurse AMHPs who had viewed the video. The aim of the study was to gain an understanding of whether decisions relating to the management and

assessment of risk vary according to the professional background of the AMHP. Proposed detention rates between social worker and nurse AMHPs were identical although variation was found across the whole sample in terms of the risks that were identified in the vignette. Stone (2017) found that a lack of knowledge about the person being assessed lowered the AMHP's threshold of risk. Additionally, Stone's participants spoke of making decisions based on feelings rather than information and interpreting risks subjectively. Stone (2017) concluded by arguing that the results suggest that differences in the way AMHPs reach decisions may well relate to a variety of individual differences rather than reflecting initial professional identity and training as so often argued in the literature. There are limitations to the study as the sample did not include occupational therapist or psychiatrist AMHPs despite the study's intention to compare professional groups.

Glover-Thomas (2011) examined individual professional and institutional responses to the mental health legislation in relation to risk. She examined whether the MHA as amended in 2007 amplified risk as a significant concern within decision-making. Glover-Thomas (2011) also examined current perceptions of patient risk-profiles, the influences of socio-political trends towards risk assessment and its management and how this is transposed into decision-making in practice. The study also considered how decision makers use risk to assist with their daily roles. The study was informed by data obtained in interviews conducted with AMHPs, psychiatrists and former clinical administrative staff, all of whom were involved in mental health decision-making either directly (decision-making affecting individual cases) or indirectly (decision-making affecting institutional and organisational design). Glover-Thomas (2011) does not provide information regarding the methodology used or sample size of participants of the study. Glover-Thomas (2011) argues that instead of acting in a binary sense, risk may apply on different levels. She contends that the conception of risk does not serve as a universal measure in mental health practice but is instead, seen as a divisible notion depending on the context in which it is deployed. Similar to Quirk (2003), Glover-Thomas (2011) found that a greater knowledge of the person being subjected to assessment raised participants' risk tolerance, conversely, participants had a lower risk tolerance for detaining people unknown to the service. For example, research participants, particularly the psychiatrists, emphasised the primacy of clinical history. Some decision-makers believed that past incidents are largely conclusive of current risk; others took the view that previous encounters with mental health services cannot prejudice an assessment of the patient's current presentation. The prejudicial impact of clinical history means that risk assessment is never wholly an objective, fact-finding exercise. AMHPs interviewed concurred with this approach, acknowledging that the outcome of a risk assessment often depended on whether a patient is "known or not known" by the mental health services — in other words, whether the individual has a psychiatric history. Interestingly, findings suggest where a service user had a history of contact with mental health services, participants felt this factor would ensure that they were much more likely to readily engage with those services again. Therefore, a main finding of the research is that "past behaviour" is regarded as the "main predictor" of a patient's current risk profile (Glover-Thomas, 2011).

The findings of Glover-Thomas (2011) are supported by Abbott (2018) who also identified clinical history as prejudicial. Abbott (2018) explored the distinction in practice between medical and social perspectives occupied by AMHPs when they use the law in circumstances where compulsory admission to psychiatric hospital is a possibility. Abbott (2018) conducted semi-structured interviews with eleven social worker AMHPs, thereby excluding other professional groups. A framework analysis was adopted, providing rich descriptions of case stories. All case stories related to assessments that resulted in detention, which may have given rise to results bias. Findings revealed the social and family situation of the person assessed, combined with views of others, and particularly the impact of risk on others, is the most influential factor in AMHPs' decision to detain (Abbott, 2018). This leads to the further argument that notwithstanding a holistic and social perspective, this does not necessarily lead to less coercive interventions. Medical and social perspectives thus often lead to the same conclusions in relation to decisions to use the law to detain. Abbott (2018) suggests that AMHPs' perspectives can be understood as occupying a socio-medical-judicial perspective. This apparent contradiction regarding the impact of AMHPs' knowledge of an individual's previous clinical history could be explained by the role of accountability and morality in decision-making, whereby risks may be interpreted from a personal perspective and therefore subject to judgements which are wide ranging and not merely technical.

The literature also pointed to a propensity by mental health professionals to use medical approaches during assessments which focussed on the mental health of the individual being assessed thus conflating mental illness with the notion of risk (O'Hare et al., 2013; Sheppard, 1990). Buckland (2016) examined how AMHPs describe, explain and understand both their own subject position in relation to compulsory detention and the process of detention itself and then analysed this in the context of normative discourses about mental ill-health and "sectioning." Semi-structured interviews were conducted with ten AMHPs focussing on a recent memorable assessment for them using Foucauldian discourse analysis approach, a methodology dependent on specific understandings about how power, language and discourse operate. Buckland (2016) found that having a mental disorder and risk were explicitly problematised by participants who located treatment for mental illness in hospitals and used medical narratives to justify detention. Contrastingly, Peay (2003) found that ASWs' narratives were from a social rather than medical perspective. Hall (2017) also found that ASWs used socially oriented language and understood crises in social terms, thereby contradicting Buckland (2016) and O'Hare et al. (2013). Hall (2017) conducted this research in 2008 and interviewed ASWs, service users, home treatment professionals and ASWs involved in nine MHA assessments using a framework analysis. The results of Hall's study may have been impacted as it focussed on assessments resulting in home treatment rather than detention.

Gale (2016) asserts there are three components of risk work that raise tension for workers namely: translating risk into different contexts; minimising risks in practice, and caring in the context of risk. Within the literature there is a clear divide on approaches to risk with some studies emphasising the importance of medical perspectives and others emphasising the importance of social perspectives in

assessing risk during assessments. This implies that there are other factors and influences outside of the application of professional values, with personal values being highlighted as one such alternative and explanation for the difference. When placed together with other factors such as age, gender and ethnicity this complicates the notion of universal human values intimated by AMHPs within research interviews. The implication of findings by Buckland (2016) and O'Hare et al. (2013) for AMHP practice is that medical perspectives are more likely to lead to decisions which result in detention than a social perspective, however Abbott (2018) contradicted this and found both social and medical perspectives lead to decisions which resulted in detention. Sheppard (1990) argues that ambiguity in the understanding of what constitutes risk potentially has a direct impact on AMHPs' threshold of risk, thus leading to differing outcomes for service-users. This is echoed by O'Hare et al. (2013, p. 200) who felt study participants had an "arbitrary understanding of risk" and Glover-Thomas (2011) who reported that participants could not explicitly define risk, but instead viewed it as self-evident. Quirk et al. (2003, p. 127) found that participants relied on "pragmatism" when applying the MHA in relation to the assessment of risk.

Although the studies examining risk have used a range of methodological and theoretical approaches, they provide a consistent finding that in the context of detention decisions there is value in knowing the person when assessing risk, as a personal connection to the person being assessed may impact AMHPs' understanding and interpretation of risk. Gale (2016) proposes that future research should focus on practitioner subjectivity and identity in risk work utilising comparative research across type of risk and different contexts to enhance this emerging field of research.

2.8 Emotional labour

American sociologist Everett Hughes (1971, p. 95) introduced the concept of "dirty work" which was further investigated by Emerson and Pollner (1976) in their ethnographic study which explored a Community Mental Health Team's (CMHT) description of encounters with service-users. CMHT members used the term "shit work" when they felt there was a lack of opportunity to help service-users in a therapeutic sense. Emerson and Pollner (1976, p. 246) noted that "the term was most frequently and vociferously used by social workers." Coercive action (in particular, application for compulsory detention to psychiatric hospital) was described as serving nothing but social control purposes. Conversely, crisis intervention and avoiding involuntary hospitalisation of service-users were seen as therapeutic work. Although conducted over four decades ago in 1976, this study provides a historical context to the emotional conflict some AMHPs experience in exercising their statutory duties such as MHA assessments and subsequent sectioning processes. The concept of "dirty work" and "shit work" shed light on the inherent complexities and ambiguities that shape AMHP practice.

Contrastingly, research by Morris (2016) analysed a collection of seventeen verbatim quotes from social worker AMHPs from across England, using dialogical narrative analysis (Riessman, 2007) to answer the research question: *AMHP Work: Dirty or Prestigious?* The AMHPs in Morris' study did not view the

involuntary detention of service-users as coercive or “dirty work.” Instead, “dirty work” (Morriss, 2016, pp. 704 – 706) was attributed to the emotional labour of engaging with people experiencing mental distress. Emotional labour is described by Wharton (2009) as the process by which workers are expected to manage their feelings in accordance with societal expectations and organisational rules and guidelines. Similar to Emerson and Pollner (1976, p. 196), Morriss (2016, p. 706) found that “proper work” is attributed to therapeutic interventions with service-users. An example of “dirty work” given by AMHPs in Morris’ (2016) study was pre-release prison evaluations. This finding is of particular relevance to this study since Black people are 40 percent more likely than White people to access mental health services through criminal justice pathways (Nacro, 2017). Other aspects of AMHP work designated as “dirty” (Morriss, 2016) were the persistent lack of suitable inpatient beds, the complexities of co-ordinating the MHA assessment; the emotional labour and challenges of working within a predominantly medical model of mental health, all of which most participants viewed as inherent to the AMHP role. There are limitations to Morriss’ (2016) findings due to the small sample of social workers used. AMHPs from other professional backgrounds may have given different perspectives and provided some transferable findings.

Vicary et al. (2019) analysed the behaviour of doctors and AMHPs involved in MHA assessments, from the perspective of AMHPs. Using the lens of the sociological concept of “dirty work” (Hughes, 1971), Vicary et al. (2019, p. 3) explored the concept of “shift,” an aspect of dirty work not yet applied in this context. “Shift” refers to AMHPs’ frustration at attempts by doctors to “shift” or pass on their work to AMHPs (Vicary et al., 2019 p. 3). Findings revealed negative perceptions of doctors’ behaviour, resulted in AMHPs experiencing significant stressors and maladaptive coping strategies, encapsulated in the verbatim phrase “role over” (Vicary et al., 2019, p. 3). Vicary et al. (2019) argue that in the dyadic relationship between doctor and AMHP, and difficulties in understanding another’s worldview raises potential problems of misperceptions and assumptions, which result in a poor service-user experience. These findings must be interpreted cautiously as data were gathered from a small sample of twelve AMHPs and suggest the authors did not set out to make generalised claims. Nevertheless, these findings provide insight into behaviours and professional tensions, as it is understood by AMHPs as well as the challenges of inter-disciplinary working.

Also prevalent in the literature is AMHPs’ experience of coercion which impacted detention decisions. In his theory paper which relates approved social work to psychotherapy, Thompson (1997) recounts and reflects on a case whereby his decision-making as an ASW was impacted due to pressure from his employer. Thompson (2003) also recounts a situation where an ASW felt pressure from management to detain an individual. Conflict between ASWs and GPs arising from detention decisions is also highlighted by (Haynes, 1990). Experiences of coercion are also echoed by Skinner (2006) and Campbell (2010) who surmised that decision-making is likely to be compromised due to pressures from both internal (organisational) and external (other professionals and institutions) forces. It can be argued that the notion of coercion is closely linked to the culture of an organisation which dictates its values, beliefs and assumptions on how people should behave and interact and how decisions should be made. Not all coercion

is implicit in nature as Quirk (2007) observed the informal influence of community psychiatric nurses' detention decisions. In AMHP practice, coercion is also linked to the previously discussed themes of risk and professional accountability.

More recently, Leah (2022) explored the concept of a "fool's errand" in relation to the role of the AMHP. Findings from a qualitative study of ten AMHPs from different professional backgrounds in England suggest AMHPs were subjected to a "fool's errand," when they were asked by psychiatrists and bed managers to practice in a way, they, themselves, considered unwise or foolish and that did not make sense in the context of their role. Leah (2022) also found that delays in securing treatment and care outcomes for mentally unwell individuals compromised AMHP practice. Findings by Carpenter et al. (2003) support the notion by Leah (2022) of a "fool's errand" and emphasise that, "Social workers were somewhat less positive about team functioning than other professionals and also experienced more role conflict" (Carpenter et al., 2003, p. 1100). Carpenter et al. (2003) also highlighted several differences in the challenges CMHT members faced depending on their professions. Social workers identified less strongly with their profession and perceived the teams as being less participative. Compared with other professions, social workers experienced greater role conflict and more stress and therefore gave lower job satisfaction ratings. In relation to the multidisciplinary aspect of AMHP practice, Abbott (2018, p. 148) describes "an adversarial atmosphere at the point of receiving the referral". Haynes (1990) identified fatigue as a barrier to thoroughly investigating a situation and a tendency to agree with doctors. Haynes (1990) conducted semi-structured interviews with twelve ASWs, though she has not been explicit about her methodology. Participants were asked what influenced their decision in their most recent out of hours assessment. Interestingly, Haynes (1990) is the only study in this review to direct attention to out-of-hours assessments.

Gregor (2010) identifies the ASW role as anxiety inducing. Similarly, Thompson (2003) adopting a psychodynamic framework in his study, also describes the ASW role as mentally distressing. This concept is supported by Dwyer (2012) who asserts that decisions are both emotional and cognitive. Findings from Morris (2016) and Stone (2017) build on this concept highlighting that AMHPs feel guilt about detention decisions but see it as inherent to the role. Peay (2003) found that the decision to detain is driven by fear of the consequences of not detaining in relation to risk. In describing the social pressures of the MHA assessment, Ferguson (2010) discussed the pressures of conducting MHA assessments in deprived, intimidating neighbourhoods, where the absence of people gives rise to unease, which, conversely, can be worse if there are people around who are potentially hostile. On the other hand, Ferguson (2010) explains that middle-class areas can give rise to highly educated relatives who may not be keen on letting the AMHP decide about whether or not to make an application under the MHA but want to make it for them - be it to section or not. In her study of twenty-five ASWs Gregor (2010) said:

"An ASW unconsciously processes a wealth of powerful emotions and feelings for service-users, their families and sometimes other professionals involved. If functioning well, the ASW is able to return these feelings in a more manageable format." (p. 10)

The literature has highlighted the emotional labour involved in AMHP decision-making which refers to the effort, energy, and emotional regulation required by AMHPs to manage their own emotions while interacting with individuals experiencing mental health issues, their families, and other professionals (Wharton, 2009). It involves displaying appropriate emotions and maintaining a supportive demeanour even in emotionally challenging or demanding situations. AMHPs often need to demonstrate empathy, compassion, and understanding while remaining professionally detached to provide effective care and support. Studies examining emotional labour in AMHP practice have highlighted how detention decisions can be influenced by coercion from within an AMHPs organisation and externally by other professionals or relatives of the person being assessed. These findings in the literature are pertinent to this study as it emphasises the significance of organisational culture, institutional practices, working relationships with multidisciplinary professionals and emotional well-being on AMHPs' ability to avoid coercion and maintain their independence in decision-making.

2.9 Intuition

Within the literature AMHP intuition is recognised as a decision-making resource and is closely linked with AMHPs' notion of morality. Different terms have been used in the literature to describe intuition in the context of professional decision-making in health care such as: broad, practical experiences (Williams, Alderson et al. 2002); practice wisdom (Dwyer 2011; Vicary 2017; Stone 2017); tacit knowledge (MacLeod & Stadnyk, 2015); common sense (Buckland, 2016). With regard to AMHP decision-making, Dwyer (2011, p. 346) asserts "There is certainly no formula for this and a decision emerges from one's cognitive thinking and emotions." The use of the term "emerges" to describe the decision-making process implies that detention decisions are not automatic and are linked to intuition among other emotions. Glover-Thomas (2011) likened intuition to a filter through which decisions were made, whilst Kinney's (2009) refers to intuition as feelings of suspicion about what needed to happen. However, Fox (2002) warns that these alternative forms of knowledge create an epistemological uncertainty.

AMHPs' fear of making the wrong decision (Stone, 2017) and the emotional burden of making the right decision (Morriss, 2016; Dwyer, 2012 and Buckland, 2016) were highlighted in some studies. Although Stone (2017) found evidence that intuition impacted AMHP decision-making, he reported participants found difficulty in articulating this. In her observation of ASWs Peay (2003) noted the significant role intuition played in ASWs first impressions of an individual subject to MHA assessment.

The concept of identity has been considered alongside intuition by some researchers such as Vicary (2017) whose findings revealed that the AMHP role embodies the concept of personhood. Skinner (2006) found that AMHPs' professional identity was assimilated into the process of MHA assessments. Similarly, "familiarity of undertaking AMHP work" (Stone, 2017, p. 117) was found to be intrinsic to the nature of the AMHP role. Dwyer (2011, p. 351) recounts the process of conducting MHA assessments and refers to

an “esprit de corps among social workers who undertake the AMHP role” as they may not feel at ease about a decision to detain until they have discussed it with an AMHP colleague the following day, relying on colleagues to provide “informal, high-quality mutual supervision” (Dwyer, 2011, p. 351). Dwyer (2011) who in the title of her journal article metaphorically likens the experience of conducting an MHA assessment to that of “walking a tightrope,” asserts that AMHP colleagues understand the work, not just from “without,” having read about it in books, but also from “within,” having experienced the work themselves (Dwyer, 2011, p. 351). When considered together the concepts of identity and intuition highlight the nature of AMHP detention decisions are not merely analytical but are influenced by other factors such as personal and professional identity.

In summary, intuition in the context of AMHP decision-making, is the ability to make quick and insightful judgments based on experience, knowledge and subconscious processing of information. It involves drawing upon one's professional expertise and tacit knowledge to sense the best course of action without relying solely on analytical reasoning. Intuition can play a significant role in situations where time is limited or complex factors need to be considered, thus allowing AMHPs to make informed decisions that might not be immediately apparent through conscious deliberation. However, it is important that AMHPs balance intuition with evidence-based practices to ensure the best outcomes for individuals from racialised communities and marginalised groups who are more susceptible than other groups to racial stereotyping and discriminatory practices.

2.10 Alternatives to detention

The literature highlights conflict between what the MHA subscribes in the legislation and how MHA decisions are carried out by MH professionals in practice. This claim is supported by Quirk et al. (2003) who conducted an ethnographic study of MHA assessments to explain non-legal and non-clinical influences on professionals' decisions about compulsory admission to psychiatric hospital. The study used observations and interviews with ASWs conducting MHA assessments from the point of referral to the point of conclusion as a method of data collection, which provided validity to the findings. Findings revealed that the likelihood of being detained under the MHA increased when there were no realistic alternatives to in-patient care. It is further suggested that this typically occurs when ASWs lack time to arrange alternatives to detention and are unsupported by other colleagues in doing this. It is suggested that local operational norms and the level of professional accountability may affect outcomes for specific MHA decisions. It is concluded that non-clinical and non-legal factors may explain some of the variations in admissions under the MHA. Quirk (2007) also conducted further analysis on the earlier study (Quirk et al. 2003). He proposed the resources made available to provide alternatives to admission are crucial to the detention decision, making the institutional context of direct relevance (Quirk 2007). Quirk et al. (2003) found that organisational culture operates on a team level, finding local operational norms in some geographic areas that promote detention as a last resort, whereas in other areas with less resources there was a sense of pragmatism favouring detention (Quirk et al. 2003). These findings by Quirk et al. (2003)

are relevant to this study as it implicates the role of institutions and organisational culture as potentially influencing the individual moral positions of AMHPs by supporting detention as a last resort or viewing detention as pragmatic.

For my MA dissertation I conducted a qualitative study where I interviewed ten social worker AMHPs from two local authorities and used in-depth interviews and a focus group which sought the perspectives of social worker AMHPs to find out how can mental health professionals mitigate the overrepresentation of BME people compulsory detained under the MHA. Grounded theory was used during the analysis of data, which consisted of participants' verbatim quotations (Aleong, 2018). Findings from my research substantiate findings by Quirk et al. (2003) who argue that the chances of being detained under the MHA are likely to increase when there are no realistic alternatives to in-patient care. Quirk et al. (2003) also viewed the lack of time to organise alternatives to detention as problematic. This claim was echoed by Kinney (2009) who suggested AMHPs were under pressure to resolve a situation quickly.

Aleong (2018) found that AMHPs placed significant prominence on the MHA assessment as a site where decisions are made and located. This approach does not address the dichotomous nature of the MHA in practice where alternatives to S2 or S3 MHA are missing from the assessment narrative. The socio-relational aspect of applying the MHA in practice is therefore lacking and could contribute to increased compulsory detention of both BME and non-BME service-users (Aleong, 2018). Participants also highlighted that further challenges in applying the MHA are encountered because the MHA and Mental Capacity Act (MCA) have been established separately and continue to operate under different court structures which do not facilitate clarity or simplicity. Campbell et al. (2001) highlight these legal complexities expected of MHSWs, which underlie the inherent tensions and emotional labour of the role. The legislative guidelines specify that if a person is objecting to what is proposed, the MHA should be used, if not, and the person lacks capacity, the MCA should be used. That is a decision with which professionals are familiar, however it is important to note that there are differences between the two Acts in terms of safeguards and after-care, differences that impact the level of intrusion into a person's life mandated by the State. Findings from research by Manteklow et al. (2002) on the use of law, including problems experienced in communicating with the person being assessed, highlight the importance of being able to merge or link the MHA and the MCA. The MMHA in its recommendations refers to the merging of the two systems as a "Fusion Act" (gov.uk, 2018, p. 14) but there is presently no firm decision as to whether this would be a feasible long-term plan. In the meantime, AMHPs continue to make challenging choices as to which system to use in relation to decisions about detention and treatment where the patient lacks the requisite mental capacity (Aleong, 2018). My findings extend those of Campbell et al. (2001) and Manteklow, et al. (2002) where making decisions under the MHA was perceived as dichotomous in terms of 'sectionable' or 'not sectionable' these limited options under the MHA directly impact detention rates for BME groups.

Both Kinney (2009) and Hall (2017) viewed the absence of power over alternatives to detention as undermining the AMHP role. Hall (2017, p. 453) is seemingly optimistic in her view of the ASW role as

“negotiator and deal-maker in exploring community provision.” On the other hand, others suggest the role is deterministic due to the limited choice of alternatives to detention (Quirk, 2003; Haynes, 1990; Buckland, 2016; Stone, 2017; Aleong, 2018; Glover-Thomas, 2018). Kinney (2009) produced a journal article which highlighted some of the key ethical issues related to the MHA assessment using his own practice experience, research and involvement with service user groups and academics. Kinney (2009) shared his feeling of personal failure which resulted from a decision to detain in the absence of alternative resources. Again, this highlights aspects of morality and personhood which are part of AMHP decision-making. Kinney (2009, p. 336) argues that “The main resource in this process is the AMHP themselves, as institutional support remains sadly lacking.” Dwyer (2011) also shared her experience of AMHP practice through a theory paper which illuminated that her moral conflict experienced as a result of detention decisions were felt personally as opposed to conflicting with the values of her organisation, a response that reiterates detention decisions are made on both a personal and professional level.

Fistein (2016) conducted a qualitative study, which described how decisions to detain are made under the MHA and highlights the gap between policy and practice. Further aims of the study were to understand MHA assessment decision-making and to describe the principles on which decisions to detain are based. Data on how medical professionals and AMHPs made decisions to detain people under S2 or S3 MHA were collected over a 12-month period. The study’s data collection methods were observational and semi-structured interviews with fourteen multidiscipline mental health professionals, which included five AMHPs. Findings reported five themes influencing the decision-making namely: availability of alternatives to detention; diagnosis, likelihood of response to treatment, mental capacity and risk assessment. Findings suggest that professionals employ their own “practical criteria” when making decisions about compulsory admission under the MHA (Fistein et al., 2016, p. 55). Both Fistein et al., (2016) and Quirk et al., (2003) reveal a focus on the importance of pragmatism when AMHPs use the MHA in practice. Both sets of researchers view this as demonstrating a gap or disjunction between the MHA in law and how it is actually interpreted and operationalised in practice.

According to Thompson (1997), the willingness of a service-user to work with him as the ASW was decisive in avoiding detention. This evokes a similar message by Hall (2017, p. 453) in the description of the ASW as “negotiator and deal-maker” in their role of coordinating alternatives to detention such as the home treatment team. This is extended by Abbott (2018) who adds that willingness and trust is also crucial to the AMHP/service-user relationship. Abbott (2018) emphasises the importance of service-users’ acquiesce to being unwell, relating this to trust in medication concordance. Similarly, (Stone, 2017) found service-user insight into having a mental illness and compliance with medication to be an important factor in detention decisions. This highlights the imposition of medical perspectives as discussed earlier. Self-control by the person subjected to the MHA assessment was regarded by Thompson (1997) as key in the consideration of alternatives to detention and the feasibility of community options.

Abbott (2018) identified risks being invoked to justify detention, and alternatives to detention only being an option if the person being assessed is willing to adhere to the alternative plan. Abbott (2018) found that the feasibility criteria for non-detention was the ability of relatives to cope with and support the person in the community. In the absence of these criteria detention was sought (Abbott, 2018). This emphasises earlier discussions of the intrinsic link between detention decisions, risk and accountability which are underpinned by the AMHPs' sense of morality and personal values.

2.11 Summary

Reviewing fifty years of literature regarding ASW/AMHP detention decisions has helped to contextualise this study and will inform its data analysis and subsequent discussion. This literature review highlighted that detention decisions are not based solely on technical or analytical judgements. Assessment of risk is a crucial aspect of detention decision with its prominence seemingly overshadowing other factors such as accountability. However, most noteworthy is the prevalence of morality which is a common thread throughout the literature and underpins AMHP decision-making. Comparing and contrasting the literature as it pertains to ASW/AMHP detention decisions, brings into question whether contemporary services are structured in a way that enables and supports AMHPs to fully engage with the moral and statutory aspects of their role. The extent to which AMHPs can apply a 'social perspective' when carrying out statutory duties under the MHA is a key area of debate throughout the literature. However, the literature has been ambiguous in terms of what this means from a practice perspective. This has major implications for how AMHPs conduct MHA assessments with BME services users. Occupying a social perspective raises questions on AMHPs' independence and autonomy, which form part of their legal mandate.

How AMHPs apply independence, autonomy along with a socio-medical-judicial perspective in practice is not well understood and the extent to which this is possible is debatable. The literature tends to place the social and medical model at odds with each other and a re-evaluation of these perspectives is required in order to understand the nuanced and complex nature of applying a social perspective within a traditionally medical model of mental health. This doctoral study seeks to fill a gap in the current literature on AMHP decision-making by examining processes within the MHA assessment in relation to the disproportionate detention of Black service-users.

The subsequent sections of this chapter will be a literature review which focusses on the link between ethnic disparities in socioeconomic and mental health indices and mental health outcomes in the UK.

2.12 What are disparities?

In healthcare, the term 'disparity' denotes an unfair difference, however a consensus about what constitutes 'an unfair difference' has not been reached despite ample literature on this topic. For this study, I rely on the definition employed by Smedley, Stith and Nelson (2003) who describe a disparity as the unequal

treatment of service-users that is not due to their treatment preferences, health care needs or underlying health conditions.

Turning now to the evidence on disparities in mental health care, most research comparing care across ethnic groups finds evidence of disparities in access and outcomes. According to McGuire et al. (2006) where disparities in mental health outcomes exist, the basis for the unequal treatment of service-users and the resulting unjustified variation in psychological wellbeing is due to the service-user's perceived racial or ethnic background. There is substantial evidence to suggest that this is a long-standing issue in mental health services that disproportionately affects people from Black ethnic groups. People from African and Caribbean groups are disproportionately detained under the MHA (Wall et al., 1999; Eaton & Harrison, 2000; Gajwani et al., 2016; NHS Digital, 2022), are less likely to enter and be referred to mental health services through their GP and more likely to be arrested by the police following a mental health crisis, which inevitably results in poorer health outcomes and often coercive forms of care in locked wards (Keating et al., 2002; Edge & MacKian, 2010; Rabie & Smith, 2013).

This differential treatment of Black people coming into contact with mental health services has been well documented, as have the issues around access to services, coercive pathways, and negative experiences of care. Over the last two decades, monitoring bodies such as the Care Quality Commission (CQC, 2011; 2022), data from national mental health statistics (NHS Digital, 2022) and high-profile reports such as the David Bennett Inquiry (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) have acknowledged these disparities and the prevalence of 'institutional racism.' Likewise, empirical research, service-user testimonies and literature reviews investigating disparities in mental health care have highlighted the persistent difficulties in Black people's experience of access and treatment in mental health services in the UK. For example, a review commissioned by the Sainsbury Centre for Mental Health (Keating et al., 2002), explored the relationship between mental health services and African and Caribbean communities. The review highlighted that Black people were more likely to be overrepresented in the most restrictive parts of the mental health system such as inpatient and forensic services and were less likely to access alternative forms of interventions, such as preventative, psychotherapeutic or specialist community mental health services than other ethnic groups (Keating et al., 2002). Other studies and reviews, conducted by Rethink (2000); McLean et al. (2003); Edge and MacKian, (2010); Mind (2013); Faulkner (2014); Rabie and Smith (2014); Islam et al. (2015); Glover and Evison (2009) and Memon et al. (2016) looking at the experiences of African and Caribbean people, also highlighted that Black people were more likely to be overrepresented in restrictive parts of the mental health system..

Ethnic disparities in mental health care and manifestations of racism highlighted in the literature although varied are all independently linked to negative health outcomes. The concept of "double stigma" has also been hypothesised in the literature, wherein BME people with mental disorders suffer discrimination not only because of their ethnic background but also because of their mental health problems (Memon et al., 2012, p. 6). The correlation between racism, stress and mental illness is well established in the literature

(Mallet et al., 2002; Hickling, 2005; Sewell, 2012; Rabie & Smith, 2013; Islam et al., 2015) and when experienced together amounts to a disease predictor and can be interpersonal, institutional or systemic (Sewell, 2012).

2.13 Ethnic disparities across socioeconomic indices

In order to understand the nature and extent of ethnic disparities in mental health outcomes, it is also important to consider the link between ethnic disparities in socioeconomic and mental health indices, mental health outcomes and access to mental health services, as well as experiences and treatment within mental health services.

The government commissioned Race Disparity Audit (Cabinet Office, 2018) examined how people of different ethnicities were treated across public services. Evidence presented from the audit showed patterns which revealed people from Black African and Black Caribbean groups poor experience across a number of socio-economic indices. People from Black ethnic groups were identified as more likely to be poor as well as in persistent poverty; falling behind in educational attainment and lower rates of home ownership; higher rates of secondary school expulsion and contact with the criminal justice system; higher rates of suicide and disproportionate rates of imprisonment. The Race Disparity Audit (Cabinet Office, 2018) also found that Black people had the lowest ratings for overall happiness and life satisfaction when compared to other ethnic groups as well as feeling that things they do in life are worthwhile. Additionally, Black women were the most likely to have experienced a common mental disorder such as anxiety or depression in the last week, and Black men were the most likely to have been diagnosed with a psychotic disorder in the past year.

Correlations between social disadvantage, ethnicity and compulsory admission to psychiatric hospital are strongly established in the literature (Hatfield et al., 1997; Modood, et al., 1997; Bhui et al., 2003; Erens, Primatesta, & Prior, 2001; Manteklow et al., 2002; Hatfield, 2008). A convincing rationale for the inclusion of social assessment in psychiatric emergencies is provided by Hatfield et al. (1997), and further supports the literature that suggest psychiatric and social vulnerability are closely linked (Thorncroft, 1991; Jarman et al., 1992;). Hatfield et al. (1997) argues that individuals subject to MHA assessments are not a random reflection of the general adult population but differ depending on key variables that indicate the impact of social circumstances in compulsory psychiatric care (Campbell et al., 2001; Manteklow et al., 2002; Campbell & Davidson, 2009).

This argument is validated empirically by Hatfield (2008) whose study provides credible findings on the impact of social factors in relation to people subject to MHA assessments. The study collected quantitative data from ASWs applying the MHA in six LAs in the North of England comprising of 14,514 assessments conducted over a nine-year period. The study's aim was to use data to establish trends in relation to the role

of the ASW under the MHA. The characteristics of the subjects of the research – people subject to MHA assessment, are discussed in the study. Indicators of social disadvantage in the study group were revealed in the substantial proportion living in social housing in contrast to the higher proportion of the general population living in owner-occupied housing. In one of the authorities there was an overrepresentation of African-Caribbean people subject to MHA assessments (15.5 percent compared with 2.3 percent in the census population). Hatfield's findings indicate that the most common factors associated with compulsory detention under the MHA were the presentation of risk of psychosis and non-White British ethnicity. However, the implications suggested by Hatfield (2008) that social workers are in unique position to identify and respond to these social issues are not established by the findings.

Webber and Huxley (2004) support this claim of overrepresentation in the findings of a case control study of emergency admissions under S4 MHA. This was conducted by examining retrospective case notes to review 300 MHA assessments in two London boroughs. There were similar findings in a large-scale quantitative study by Audini and Lelliott (2000) where 31,000 cases of admission under part 2 of the MHA (sections 2, 3, and 4) were analysed for demographic variables. Overrepresentation of BME people subject to compulsory admission to a psychiatric hospital was indicated in the findings that reported that BME people were six times more likely to be subject to compulsory powers under the MHA.

Furminger and Webber (2009) provide a contrast to findings, which link social factors and the application of the MHA in their study that examined a random sample of MHA assessments of a Crisis Resolution Home Treatment Team (CRHTT). The study's findings indicate that the presence of the CRHTT was associated with a significant increase in the use of S2 MHA, although the use of S3 MHA decreased. The aim of the study was to investigate the reasons for the increase and to discover the influence of the introduction of the CRHTT on the use of the MHA. This was done through focus groups to obtain the perspectives of MH professionals about the reasons for the rise. It was reported that ASWs indicated that some people were assessed for detention because the CRHTT had rejected their referral, but they were still at risk of admission. People were also detained due to the increasing difficulty in arranging voluntary admissions due to a shortage in availability of inpatient beds. The disproportionately higher rates of compulsory hospital admission and home crisis treatment among BME groups suggest that those who do reach CRHTTs are more unwell than the White group overall. This supports Bhui et al., (2003) who claim that people from BME groups tend to come into contact with mental health services later and more often at crisis point. This is also consistent with figures that show people from Black ethnic groups are over-represented in compulsory detention under the MHA (NHS Digital, 2022).

The literature also points to the importance of gender and class considerations, as research shows that they are key determinants influencing and exacerbating the rates of compulsory detention in BME communities. For example, a 2017 study by The Prison Reform Trust found that when compared to women from other ethnic groups, Black women, who are more likely to be single mothers, are also more likely than other women to be remanded or sentenced to custody, and face longer sentences (The Prison Reform Trust, 2017).

Watson et al., (2019) conducted a mixed method systematic review of fifteen studies which included women from a range of minority ethnic backgrounds and were all undertaken in UK. The research adopted a convergent approach for the analysis and thematic synthesis of the data. Findings revealed that postnatal depression and anxiety in mothers from racialised communities is 13 percent higher than in White mothers. Watson et al. (2019) concluded that a lack of awareness about mental ill health, cultural expectations, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers all impact on ethnic minority women's ability to receive adequate perinatal mental health support in the UK. Black women are the group least likely to initiate treatment for postnatal mental illness. The assessment of confidence in the findings by Watson et al. (2019) were strengthened by the involvement of a multidisciplinary study team in the development of the search strategy and the final analytic themes.

A study by Edge and MacKian (2010) focussed on two key points of interest: firstly, Black Caribbean women's approaches to help seeking and secondly, their experiences of receiving help from professional 'help-givers.' The study used a purposive sample of twelve Black Caribbean women drawn from a larger mixed-method study into depression during and after pregnancy among Black Caribbean women. Participants were interviewed in-depth approximately six months following childbirth. Findings revealed that African Caribbean women are at increased risk for mental health problems during the perinatal period, which can adversely impact their children and wider family networks (Edge & MacKian, 2010). Accounts from Black women suggest that their own emphasis on self-efficacy combined with powerful social imperatives to be "Strong Black Women" (Edge & MacKian, 2010, p. 13) and fear of stigmatisation were powerful barriers to help-seeking and accessing mental health services (Edge & MacKian, 2010). This echoes the concept of 'silent suffering,' (Kovandzic et al., 2011) which is sustained by suppressing awareness or hiding expressions of suffering due to social unacceptability of being unwell. This phenomenon is referred to as "stigma of disease" (Kovandzic et al., 2011 p. 269). These attitudes indicate that symptoms of mental distress are deemed unacceptable by some BME groups, and should be avoided or at least hidden from others. This consequently forms a barrier to accessing any kind of mental health support, whether formal or informal).

Racism has also emerged as a powerful and specific form of social disadvantage within the literature. Sewell (2012) argues that the relationship between racism, stress and mental ill health is well acknowledged in the literature. Manifestations of racism are varied but are all independently linked to negative health outcomes. Black men are stereotyped as weed-smokers, violent, aggressive or schizophrenic (Faulkner, 2014). Moreover, compulsory psychiatric admission has been associated with a diagnosis of schizophrenia in African-Caribbean men in the UK (Keating et al., 2002; Fernando & Keating, 2008). While the literature indicates a willingness to consider how racism may play a role in increased incidence of psychological distress, much of the British research has been criticised regarding its preoccupation with biological explanations for this issue (Sashidharan, 2001; 2003).

Jamaican psychiatrist Professor Frederick Hickling (2005) points out the evidence regarding the Black incidence rate of schizophrenia is shifting in favour of factors of social alienation and racism experienced by Black people in the UK, and to misdiagnosis by White British psychiatrists. Hammack (2003) notes that an individual's minority status represents an intrinsic stressor, Bhugra and Ayonrinde (2001) also draw attention to the idea that oppression is likely to act as a chronic stressor, and that chronic racism may well precipitate psychiatric disorders. Moreover, it has been suggested that psychiatry as a discipline is inextricably linked with racism (Fernando, 1988, 2017; Sashidaran, 1990, 2001; Timimi, 2005). As such, racial bias in psychiatric diagnosis might also be an important factor in the disproportionately higher rates of schizophrenia diagnoses of Black people, which may be linked to disproportionate rates of compulsory psychiatric detention of that group of service-users. Interestingly, over the past two decades sociological factors have been given recognition regarding the dynamics of 'ethnic schizophrenia' in the UK (Boydell et al., 2001, Mallett et al., 2002; Whitley et al., 2006). For these reasons, the role of the AMHP needs to be considered when examining processes which lead to the disproportionate compulsory detention of Black service-users.

2.14 Contributory factors for ethnic disparities in socioeconomic and mental health indices

In order to understand the nature and extent of ethnic disparities in mental health outcomes, the link between ethnic disparities in socioeconomic and mental health indices, access to mental health services, as well as treatment and experiences within mental health services must be considered. The sections that follow discuss the literature in relation to these issues.

As part of its stated objective to be "an essential resource in the battle to defeat ethnic injustice" within England (House of Commons, 2018, p. 3) the Race Disparity Audit (Cabinet Office, 2018) highlighted notable disparities in outcomes across a number of social indices for people who were defined as Black African and/or Black Caribbean. They were identified as the ethnic groups who were more likely to be falling behind in educational attainment; to be poor as well as in persistent poverty; to have lower rates of home ownership, higher rates of unemployment and higher rates of contact with the criminal justice system. This section of the literature review will examine the extent of these and other interconnected social problems and their links to the increased incidence of mental ill health amongst people from Black ethnic groups in the UK. Through an awareness of intersectionality, we can better acknowledge and ground the differences among us as "intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects" (Crenshaw, 2017, p. 1).

2.14.1 Poverty

The World Health Organisation (WHO, 2014) report on the social determinants of mental health highlighted that mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live (WHO, 2014). Poverty increases the risk of mental health problems and can be both a causal factor and a consequence of mental ill-health (WHO, 2014).

Elliot (2016) published a review, which contains a conceptual framework for understanding the relationship between poverty and mental health. The review drew together: a life course analysis; a discussion of the socio-economic factors (or social determinants) impacting mental health and poverty; equity and the principles of human rights. Elliot (2016) argues that in order to strengthen the evidence base, mental health must be addressed within poverty data and research, and, likewise, poverty addressed within mental health data and research. The review recognised the corrosive impact of stigma and discrimination on people experiencing mental health problems and those living in poverty.

Further, there is debate about whether income-based measures of poverty serve as an accurate and relevant measure of poverty. The Social Metrics Commission (SMC) was formed in 2016 and is led by the Legatum Institute's CEO, Baroness Stroud. It is an independent and non-partisan organisation dedicated to helping policymakers and the public understand and take action to tackle poverty. Since its inception, its ultimate goal has been to develop new poverty metrics for the UK based on the extent to which someone's resources meet their needs. This accounts for differences among households such as costs of childcare and disability, savings and access to assets. The SMC also provides detailed analysis of the nature of poverty including characteristics that impact the experience of poverty, using SMC poverty numbers, such as experiences of community, family finances, health, and labour market opportunity.

According to the SMC (2020), nearly half of Black African Caribbean households are in poverty, compared with just under one in five White families, while BME families as a whole were between two and three times as likely to be in persistent poverty than White households. The commission reported that all people in poverty – particularly those classed as in 'deep poverty,' meaning they lived at least 50 per cent below the breadline – had been far more likely to suffer reduced incomes since lockdown, increasing the risk that the COVID-19 pandemic would drive a significant increase in the incidence and severity of poverty.

SMC data shows that the largest proportion of those in poverty (75 per cent, equating to 10.7 million people) are in families with a head of household who is White. However, the rate of poverty is much higher for BME families (SMC, 2020). Nearly half (46 per cent, equating to 900, 000 people) of all people living in families where the household head is Black/African/Caribbean/Black British are in poverty, compared to just under one in five (19 per cent) of those living in families where the head of household is White. People

in BME families are also between two and three times more likely to be in persistent poverty than people in White families (SMC, 2020). Persistent poverty refers to someone who has been in poverty in three of the past four years. People in persistent poverty are at particularly high risk of having poor physical or mental health (Marmot et al., 2020). Rates have stayed roughly the same since 2010, at about 13 per cent (Marmot et al., 2020). BME households in the UK are over twice as likely to live in poverty as their White counterparts, leaving them disproportionately exposed to job losses and pay cuts which has become more prevalent since the COVID-19 pandemic (SMC, 2020).

Kenway and Palmer (2007) examined how the rates of persistent poverty differ between different ethnic groups and provide an analysis for the reasons for some of these differences. According to Kenway and Palmer (2007), single parent households have the highest risk of being in persistent poverty than other household types. It follows that, if a particular ethnic group has a relatively high number of single parent households, this could go some way to account for its higher income poverty rate. What stands out for Black African and Black Caribbean households is the high proportion of persons who are either single parents (15-20 per cent) or working-age living alone (25- 30 per cent).

2.14.2 Educational attainment

“As with inequalities in early years, inequalities experienced during school years have lifelong impacts - in terms of income, quality of work and a range of other social and economic outcomes including physical and mental health” (Marmot et al., 2020, p. 21). There are long-standing concerns about inequalities in educational attainment in England in relation to ethnicity, socio-economic status (SES), and gender (Strand, 2014, 2010, 2011, 1999; Sirin, 2005; DES, 1985; Douglas, 1964). However, there is a paucity in research which has analysed and evaluated interactions between these variables.

Strand (2014) evaluated interactions between SES and ethnicity in their interactions with educational attainment. Strand (2014) analysed the national test results at age 7 and age 11 of 2,847 pupils attending 68 mainstream primary schools in an ethnically diverse inner London borough. The largest group in the sample was Black African pupils (33 percent) followed by White British (25 percent) and Black Caribbean (12 percent). The other ethnic groups each constitute around about 5 percent of the sample. Although White British are not the largest group, for the purpose of comparison they were used as the reference group since they are the majority group in England. The groups with the lowest educational achievement and poorest progress were both Black Caribbean and White British low SES pupils. White British middle and high SES pupils made significantly more progress than White British low SES pupils which resulted in the widening of the SES gap over time. However Mixed White and Black Caribbean, Black Caribbean and Black African pupils from middle and high SES backgrounds made no more, and in some cases even less, progress than their low SES peers (Strand, 2014).

Strand (2014) sought to answer the key question: *Why do Black pupils from middle and high SES backgrounds not benefit from higher educational attainment as their White British peers do?* In addressing this questions Strand (2014, p. 27) argues that “the greater progress of White British high SES pupils may reflect the stronger access to social and economic capital exerted by high SES pupils.” Although Black and White pupils may come from similar neighbourhoods in terms of deprivation, equity gaps may be influenced by key systemic factors. These include differences in economic and social capital of families, neighbourhood or peer effects, the home learning environment, educational aspirations, parental education and involvement and other factors outside school (Strand, 2014; Kiernan & Mensah, 2011; Mandara et al., 2009; Strand & Winston, 2008).

2.14.3 Housing

People with mental health problems are far less likely to be homeowners and far more likely to live in unstable environments (Johnson et al., 2006). People with mental health problems are more likely to find themselves in rented accommodation, social housing, and in poor housing with damp and mould problems (Mental Health Network, 2011). Part of this is due to their lower socioeconomic life chances in addition, poor conditions, frequent moves and nearby antisocial behaviour can exacerbate problems. People with mental health problems are twice as likely as those without mental health conditions to be unhappy with their housing and four times as likely to say that it makes their health worse (Social Exclusion Unit, 2004). Mental ill health is cited as a reason for tenancy breakdown and housing problems are often given as a reason for a person being admitted, or readmitted, to inpatient care (Johnson et al., 2006).

In the 2 years to March 2019, an average of 17 percent of households in England lived in a home with no modern facilities, no effective insulation or heating, or in a state of disrepair (a “non-decent home”) [Gov.uk, 2020]. Mixed White and Black African households (33 percent) were more likely to live in a non-decent home than White British households (gov.uk, 2020c).

Around 2 out of every 3 White British householders owned their home either outright or with a mortgage in 2015/16, but only 2 out of 5 householders from all other ethnic groups combined did (Cabinet Office, 2018). Compared with all other households, White British householders were most likely to own their own home within every region of the country, every socio-economic group and income band, as well as all age groups. All the Black ethnic groups were disproportionately likely to live in the most deprived neighbourhoods (Cabinet Office 2018).

2.14.4 Employment

According to the WHO (2014, p. 24), “unemployment and poor quality employment are particularly strong risk factors for mental disorders and are a particularly significant cause of inequalities in mental disorders, as risk of unemployment and poor quality employment closely relates to social class and skill levels.” A decade on from the landmark 2010 study ‘Fair Society, Healthy Lives- The Marmot Review’ (Institute of

Health Equity [IHE], 2012), the increase in health inequalities in England points to social and economic conditions, many of which have shown increased inequalities or deterioration since 2010 (Marmot et al., 2020). In its report, *The Marmot Review* (IHE, 2012) highlights health impacts of economic downturns, describes evidence suggesting close associations between job loss and symptoms (though not clinical diagnoses) of depression and anxiety. Conversely, job security and a sense of control at work are protective of good mental health (Catalano et al., 2011).

According to the National Mental Health Development Unit (2021), for those with mental health problems, being employed can be an important step to recovery, improving self-esteem and confidence and reducing psychological distress. Conversely, unemployment increases the risk of developing mental health problems, and is associated with increased rates of depression and suicide as well as higher use of health services and hospital admission. Employment is therefore vital for maintaining good mental health and promoting recovery from mental health problems (Mental Health Foundation, 2012). Since the start of the COVID-19 pandemic, employment has generally been decreasing and unemployment increasing (Office of National Statistics [ONS], 2021). However, estimates for January to March 2021 show signs of recovery, with a quarterly increase in the employment rate (ONS, 2021).

Unemployment statistics published in January 2021 show that within the economically active population 4 per cent of people from White ethnic groups were unemployed in 2019, compared with 7 per cent of people from all other ethnic groups combined. Black, Bangladeshi and Pakistani people had the highest unemployment rate out of all ethnic groups (8 per cent) [gov.uk, 2021]. The White Other ethnic group had the lowest unemployment rate out of all ethnic groups (3 per cent). In every region in England, unemployment rates were lower for White people than for all other ethnic groups combined. Among 16 to 24 year olds, unemployment rates were highest for people from a Black background (26 percent) and from a Pakistani or Bangladeshi background (23 percent) compared with White people (11 percent) [Powell, 2019].

Even when employed, men and women from some ethnic groups are paid less on average than those from other groups with similar qualifications and experience (Barnard & Turner, 2011). According to poverty statistics in the UK (Fancis-Devine et al., 2021) levels of persistent low income were higher in households where the head of household was from certain ethnic groups. They reported that 15 percent of people from a Black/African/Caribbean/Black British background were in persistent low income before housing costs (BHC) and 25 percent after housing costs (AHC). For people from an Asian/Asian British background, the proportions were at 17 percent BHC and 22 percent AHC, 2 percent of children in lone parent families were in persistent low income BHC and 35 percent AHC (Fancis-Devine et al., 2021).

Although employment rates in England have risen since 2010, the risk of being unemployed and particularly long-term unemployed is still highly unequal between different groups. According to Marmot et al. (2020)

White people, married men, people with no disabilities and those with higher qualifications have higher employment rates than Minority Ethnic groups, women, single parents and people with disabilities. Marmot et al. (2020) also found that the health risks associated with unemployment, and particularly long-term unemployment, are high and include higher mortality rates for those long-term unemployed.

2.14.5 Criminal Justice

The Ministry of Justice compiled statistics from data sources across the criminal justice system (CJS) in England and Wales over a decade from 2008 to 2018. A report was produced which provides the combined perspective on the typical experiences of different ethnic groups. The report has consistently shown that people from Black ethnic groups who come into contact with criminal justice agencies are overrepresented at most stages throughout the CJS when compared with the White ethnic group (gov.uk, 2019). The greatest disparity appears at the point of stop and search, arrests, custodial sentencing and prison population (gov.uk, 2019).

An independent review into the treatment of BME people in the CJS by Labour MP David Lammy found that high numbers of Black people coming into criminal justice settings, coupled with the discrimination they experience once there, result in the CJS often acting as a gateway to the mental health system for many Black offenders (Lammy, 2017). Significantly, the Bradley Report (Taylor, 2010) of people with mental health problems or learning disabilities in the CJS, found that people from BME groups were 40 percent more likely than White groups to access mental health services through the CJS (Taylor, 2010).

For the year ending March 2019, Black victims accounted for 14 percent of overall homicide victims. This is an increase compared with the previous year and the highest number of Black victims since 2001 to 2002 (ONS, 2020). According to Laurence (2015), Black people in England are more likely to be exposed to, or engaged with, higher rates of violent crime. Overall, the dominant discourse surrounding Black young men and boys in the news media links them with violent crime, and particularly murders involving knives and/or gangs (Gunter, 2017; Cushion et al., 2011; Alexander, 2008). It is reasonable to assume that the negative portrayal of young Black men in the news media may well impact on the wider readership and viewing public's perceptions of these groups. This in turn may lead to Black people being reduced to stereotypes in which they are viewed as trouble makers or at the forefront of deviance, conflict and violence.

Reports into decision-making in the CJS has shown that professionals often more readily associate Black defendants with a sense of danger (Crown Prosecution Service, 2023; Shiner et al., 2022; Wunsch et al., 2016; Lammy, 2017). Studies which examined Black people and the CJS, where interviews were conducted with criminal justice officials including magistrates and probation officers, found that they are more likely to err on the side of caution with Black mentally vulnerable defendants and to be affected by a heightened perception of dangerousness (Shiner et al., 2018; Keating, 2016; Shankley & Williams, 2020; White et al.,

2020). A study into the application of the MHA found that police officers are prone to associating Black people with risk factors, which resulted in Black people being more likely to be detained by police under S136 MHA and taken to a ‘place of safety’ within the meaning of the Act – often a psychiatric hospital – thereby opening that channel into the psychiatric services (Docking, 2009).

Young Black men in particular, are more likely to end up with an extremely racialised profile of their mental health. This is because ‘uncooperative behaviours’ by Black men are implicated in perceptions by mental health professionals of them being ‘Big, Black, and Dangerous’ a phrase coined in the 1993 Report of the Committee of Inquiry into the death of Orville Blackwood, a patient in Broadmoor Hospital, and of two other African-Caribbean patients (Prins, 1993). The report claims that compared to other ethnic groups in England, Black people are most likely to have police involvement in their admissions, be detained and to receive secure care in a locked psychiatric ward. Black people are also most likely to be diagnosed with schizophrenia, given higher doses of medication and are least likely to receive psychotherapy (Prins, 1993). Disturbingly, the perception by professionals that these patients were ‘Big, Black and Dangerous’ was given so frequently to the Committee that the phrase was included in the report title, albeit with a question mark. The impact of racial stereotyping on MHA assessments is highlighted throughout the literature, (Memon et al., 2012; Memon et al., 2016; Edge and MacKian, 2010; Keating et al., 2002). Therefore, the evidence shows that more punitive and restrictive forms of treatment are meted out to people from Black ethnic groups. This could be linked to raised rates of involuntary detention under the MHA for this group.

The fact that there are disproportionate numbers of Black people coming into the mental health services from a criminal justice context means that this group of mentally disordered offenders is often viewed by staff as presenting an increased security risk compared to that posed by other groups. Prins (1993) whose inquiry examined the treatment of Black mentally disordered offenders found they were more likely to be detained in the locked wards of psychiatric hospitals and more likely to be transferred to higher security facilities. Professionals made a strong link between Black patients and a notion of heightened risk, with the result that additional safety precautions were frequently seen as necessary. For example, ASWs were more likely to request police presence when taking a Black patient to hospital (Prins, 1993).

2.14.6 Trauma

Experiences of trauma can also disproportionately affect people from BME backgrounds. According to the UK Trauma Council (UKTC.org, 2022), “Trauma refers to the way that some distressing events are so extreme or intense that they overwhelm a person’s ability to cope, resulting in lasting negative impact.” Khunti et al., (2020) argue that social threats in day-to-day life due to individuals’ experiences of racism (either structural or as a result of another’s actions) can lead to psychosocial stress which has direct biological effects. Research suggests that experiencing racism can be very stressful and have a negative effect on overall health and mental health (Williams, 2018; Gibbons et al. 2012; Williams & Williams-Morris, 2000; Bhui et al., 2018). Furthermore, stress has been associated with less effective immune

functioning (Hussain et al., 2020). There is a growing body of research that suggests that those exposed to racism may be more likely to experience mental health problems such as psychosis and depression (Wallace et al., 2016; Bhui et al., 2018).

While racism operates through exclusion and oppression to produce trauma among Black people Tyler et al. (2022) argue that whiteness operates similarly to produce race-based traumatic stress. With this premise, we examine ‘White Privilege,’ a term that is highly controversial and contested. The phrase was coined in the US in the late eighties, when Peggy McIntosh, an American women’s-studies scholar, started writing about it. In 1988, McIntosh wrote a paper titled ‘White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences Through Work in Women’s Studies’ (McIntosh, 1988). McIntosh (1998, p. 2) describes White privilege as ...“an invisible package of unearned assets that I can count on cashing in each day, but about which I was ‘meant’ to remain oblivious.” McIntosh (1988) listed forty-sixty examples of White privilege which were daily experiences that she took for granted, as neutral, normal, and universally available to everybody. Some examples of ‘White privilege’ noted by McIntosh (1988) are:

“7. When I am told about our national heritage or about "civilisation," I am shown that people of my colour made it what it is” (p. 5).

“15. I did not have to educate our children to be aware of systemic racism for their own daily physical protection” (p. 5).

“23. I can criticise our government and talk about how much I fear its policies and behaviour without being seen as a cultural outsider” (p. 6).

“27. I can go home from most meetings of organisations I belong to feeling somewhat tied in, rather than isolated, out of place, outnumbered, un-heard, held at a distance, or feared” (p. 6).

“32. My culture gives me little fear about ignoring the perspectives and powers of people of other races” (p. 6).

“41. I can be sure that if I need legal or medical help, my race will not work against me” (p. 7).

The notion of ‘White privilege’ implies that it is White people’s attitudes and behaviours that primarily cause the disadvantage experienced by non-White groups. It also reinforces the perception that being non-White and/or Black is to be treated unfairly by default. Blum (2008) critiques the concept of ‘White privilege’ and argues that it inadequately explores the actual structures of racial disparity in different domains (health, education). In his analysis of White privilege, Blum (2008) offers what he terms ‘mild’ criticisms which include: a tendency to deny or downplay differences in the historical and current experiences of the major racial groups; its failure to recognise important ethnic differences within racial groups; and its overly narrow implied political project that omits many ways that White people can contribute meaningfully to the cause of racial justice.

Absent from most conceptual and research analyses of trauma is the experience of historic disadvantage and discrimination resulting from racism as causal or aggravating factors in the development of psychological distress or poorer quality of life (Helms, Nicolas & Green, 2010; Wallace et al., 2016). However, for Black people, these experiences can present real threats to personhood, sense of self and wellbeing (Bryant-Davis & Ocampo, 2005). The systematic dehumanisation of African slaves has been identified as the first significant form of trauma experienced by Black people (Alleyne, 2017). It was followed by centuries of structurally oppressive and racist practices, which resulted in what is understood as the intergenerational transmission of trauma or legacy of pain passed on from one generation to the next. The effects can still be observed within Black communities. Cognitive impairments such as loss of memory and difficulty remembering, and somatic symptoms such as headaches, body pains and aches, and trouble sleeping are reported (Bryant-Davis & Ocampo, 2005). Victims of trauma as a result of racism are likely to respond to their experiences by engaging in self-blame, or exhibit feelings of confusion, shame, and guilt (Carlson, 1997; Carter, 2007; Polanco-Roman et al., 2016). These symptoms are further exacerbated when people's experiences of racism as traumatic are undermined or misunderstood by others, their peers or professionals (Sue, et al., 2007). For these reasons, mental health must be considered within the context and complexity of historical trauma that remain potent causative factors in contemporary mental illness (Hickling, 2020). This includes the complex colonial history of African-Caribbean people and the trans-Atlantic slave trade that underpinned British colonial rule and the subsequent migration of African-Caribbean people to Britain.

2.15 Colonialism, migration and Black mental health

During the 18th century building the British Empire involved colonialism, which is when one country gains control over another country, region or people and includes the establishment of new settlements, institutions and civic structures (Hickling, 2020). Colonialism was a system buttressed by the ideology of White supremacy and engineered through brutality and fear. It also included the exploitation of people and natural resources for profit (Sutherland, 2006). In the European context of colonialism this can be seen very clearly with the trans-Atlantic slave trade which was the trafficking of Africans (the buying of slaves in Africa, transporting them across the Atlantic Ocean to the Caribbean and then reselling them to people who wanted cheap labour).

According to Hickling (2020), colonialism was a meticulously manicured system of apartheid that privileged the rights of White British people and relegated all others to inferior status. Many fundamental aspects of Caribbean society were fashioned by this colonial apartheid system such as the military, judiciary, police and prisons, education and health – including mental health. In the initial period of slavery, a slave displaying signs of severe mental illness would be summarily executed or detained in the Royal Gaol [jail] (Hickling, 2020). Slavery was abolished in 1833, however, post-emancipation, the sole care model for mentally ill African-Caribbean people was situated in vast Victorian institutions such as the

Bellevue Lunatic Asylum in Jamaica, built by the colonial government. Bellevue and other mental asylums in the Caribbean, followed the same principle of involuntary detention that had been a brutal hallmark of the slavery system (Hickling 2020).

Crucially, amongst Caribbean countries such as Trinidad and Jamaica, community mental healthcare has replaced the traditional approach marked by involuntary certification and detention (Hickling, 2020; Sharpe & Shafe, 2016). However, the legacies of slavery still reveal themselves in contemporary psychological problems in Caribbean countries such as authority issues, oppressive or authoritarian sexual and social practices, and dependency issues (Lacey et al., 2016). The uneven distribution of resources in the post-colonial era fuelled extensive socioeconomic inequality and disenfranchisement within Caribbean societies giving rise to culture of crime and violence. This is evident in Jamaica where the murder rate is almost eight times the global average and the third highest in the world (Hickling, 2020; Jamaica Constabulary Force, 2022).

2.15.1 Emancipation and African-Caribbean migration to Britain

Post slavery, African-Caribbean people were recruited and many volunteered as colonial subjects in Britain for military or navy service during the First and Second World War (1914-1939). Soon after, thousands arrived to work in the war industries and the merchant navy. While establishing communities in the seaports and major cities, their presence was often met with conflict (Sutherland, 2006).

Up until the mid-1950's, due to shortages in the UK's labour force and the need for workers to help with the post-war reconstruction of Britain, African-Caribbean migration to Britain increased. It is estimated that about a quarter of a million African-Caribbean people arrived to settle permanently in Britain between 1955 and 1962. The British government then moved to pass the Commonwealth Immigrants Act 1962 (legislation.gov.uk, 2022) restricting the entry of immigrants. Despite their war service and British nationality, the Colonial Office negatively stereotyped African-Caribbean migrants as lazy, irresponsible, quarrelsome, suspicious and needy aliens who were deserving of public disapproval (Paul, 1997). African-Caribbean immigrants were relegated to low paying jobs and to materially and socially disadvantaged neighbourhoods (Lashley, 1986), and were subjected to racial violence that many had never expected. It was also the case that White racist hostility was provoked by African-Caribbean males' intimate relationships with White women (Smith, 1981).

During this period, White British people argued that a substantial increase in Black people would result in housing, employment and social services problems. A fundamental concern was the possible impact of Black migration on the White British racial character and national identity (Solomos, 2003). There were demands to control the Black population and for Caribbean people to be repatriated to their country of origin. Williams (1986) indicated that Black people came to be defined as "a separate group, as alien, or inevitably culturally different and as a threat to the rights, status and rewards of citizens of an otherwise

culturally and politically homogenous society” (p. 137). It was also the case that by the 1980s, British immigration policy had two prongs. There were strict controls on entry, however the State claimed that it would protect the rights of ethnic minorities. However, Kyriakides and Virdee (2003) assert that “... while racism is considered immoral in Britain, the role played in immigration restrictions in perpetuating a racist climate continues respectably and relatively unnoticed.”

Recent research and analyses of postcolonial implications on mental health of people of African and African-Caribbean heritage are scarce. An exception is the work of Adewale et al. (2016) who used postcolonial perspectives in their research of African and African-American mental health. Using semi-structured surveys, 31 African-Americans and 29 Nigerian-Americans were interviewed. These two populations were chosen on the basis that slavery would influence African-Americans and colonialism would influence Nigerian-Americans. Adewale et al. (2016) found that Nigerian-Americans and African-Americans have different viewpoints on various mental health issues such as eating and mood disorders, but share similar viewpoints on other issues such as the negative impact of slavery and colonialism on mental health. The underlying conclusion is that umbrella terms used to describe ethnicity could lead to blanket policy and practice responses that do not take diverse individual needs of minority communities into account terms African-American, Nigerian-American, and other derivations of Black Americans should be considered separately when understanding mental health perceptions. Furthermore, Adewale et al. (2016) argue that the impact of major historical events such as slavery and colonialism should be understood when assessing the mental health.

2.16 Summary

In the literature review, the nature and extent of racial and ethnic disparities in mental health outcomes were considered within historical, economic, and socio-political contexts. People from BME backgrounds, were found to be more likely to experience socioeconomic disadvantage, poverty, racism and other forms of discrimination, than White British groups. Black people were most affected by experiences of historical social disadvantage resulting in poorer psychological functioning as indicated by social (higher levels of unemployment, poverty and contact with the criminal justice system), and wellbeing (higher levels of psychological distress) indices. Higher levels of distress were also linked with current and historical trauma marked by racism enslavement, colonisation, migration and assimilation into mainstream British society.

Chapter 3. Institutional ethnographic methods

3.1. Overview of chapter

This chapter provides an overview of IE, the method of enquiry used to accomplish the aims of this study. The methodology and the identity of the researcher are inextricably linked in the study. Therefore, the study does not play down the researcher's identity/position within it. The chapter begins by outlining the researcher's ontological and epistemological assumptions that underpin this study. Next, how these assumptions have informed the institutional ethnographic methods of data collection and analysis employed are outlined. Finally, the vocabulary associated with IE, its key methodological concepts, ethics and the process for data collection and analysis used within this study are explained. Following the approach of Wolcott (2009, p. 25) the methodology is presented as a "personal narrative through which you (the researcher) introduce the study in the manner that it was experienced, reaching as far back as you feel necessary to put things in context."

3.2 Introduction

The purpose of this study is to gain nuanced knowledge of the processes applied by AMHPs in the involuntary detention of Black people under the MHA in England. IE was utilised as a social theory and method of inquiry as it offered ways to gather first-person perspectives on experiences and occupational participation, as well as understanding how the "work" of AMHPs is organised in an institutional setting. Importantly, IE provided an understanding of how AMHPs' role in sectioning processes under the MHA is mediated and how this is coordinated through texts (Smith, 2005).

3.3 Reflexivity and envisioning a research need from my social location

"Research is always carried out by an individual with a life and a worldview...a personality, a social context...all of which affect the research...." Bentz and Shapiro (1998, p. 4). My ethics, experiences of, and position within society, as well as my philosophical orientation have influenced the way in which I have approached this project with respect to the research topic, questions and the methodology used.

Consistent with IE's criteria for the researcher to identify their position (Smith, 2006), my methodology acknowledges an awareness of my presuppositions going into this research. Correspondingly, reflexivity is used to explain how my values influenced the study and to effectively de-mystify how results and interpretations are arrived at. In other words, reflexivity is not only about producing authentic results but also about being clear about the process of their production (Thomas, 1993). As such, reflexivity maintains not only that the researcher's social location be considered (Trevithick, 2008) but also that this location diminishes any claim of objectivity (Walby, 2007), making space consequently for the premise of multiple truths. The practice of reflexivity has been an integral part of conducting this qualitative research. Gough (2003, p.22) argues that reflexivity "facilitates a critical attitude towards locating the impact of research(er)

context and subjectivity on project design.” Likewise, Willig (2013) argues that the concept of reflexivity is borne out of the awareness of the researcher’s contribution to and involvement in the construction of meanings over the course of the research and an acknowledgement of the impossibility of remaining outside and completely objective of the subject matter while conducting research. Thus, this chapter acknowledges that epistemological and personal reflexivity form an integral part of the research process (Willig 2013).

3.3.1 The Influence of my practice and standpoint on the research

Trevillion (in Shaw, et al., 2009) highlighted that little is known about the way that practice influences research. He argues that the relationship between research and the practice contexts in which it takes place, is one of the most important and yet poorly understood issues facing social work (Trevillion in Shaw et al., 2009). The influence of my social work practice on the issues investigated in this study can be traced to my academic training and subsequent qualification as a social worker. I discuss this to situate myself, similar to other feminist scholars who introduce themselves into the narrative of their research as an explicit decision (Harding, 1988; Smith, 2005; Collins, 1998, 2000). As a social worker and Black Caribbean woman, my personal and professional interest in this area of research was piqued and continued to develop over the course of my post-qualifying research, where I investigated AMHPs’ perspectives on how the disproportionate detention of service-users from BME backgrounds under the MHA can be mitigated. I was made aware that the circumstances surrounding an individual such as gender, race, ethnicity and socio-economic status could influence the way that their experiences of mental distress are perceived by and impacted on others. This in turn could significantly determine how mental health professionals respond to and assess the needs of individuals.

Through my previous research, I became more aware that in practice, sectioning processes under the MHA were complex and could not be simply thought of as a linear process involving a rational/technical application of knowledge of legal rules applied to the circumstances of a case. I had a sense that when AMHPs applied the MHA there were other contingencies at play in deciding whether or not someone should be detained. In the past, social work has been criticised for maintaining an illusion of neutrality and minimising critical examination of systems that affect individuals (Abramovitz, 1993; Fisher, 1995; Karger and Hernandez, 2004; Howard, 2010). With this in mind, I began to think more critically about the mental health system, in particular sectioning processes under the MHA, with specific interest in how institutional processes impact the continued disproportionate compulsory detention of Black service-users. My previous research findings (Aleong, 2018) revealed a complex web of interrelated factors which acted as barriers to BME people accessing mental health services for example: structural barriers such as discrimination and institutional racism (Fatimilehin and Coleman, 1999; Memon et al., 2016; Jeraj et al., 2015; Rabiee and Smith 2013); cultural barriers such as the stigma and shame of mental illness (Memon et al., 2016; Edge and MacKian 2010; Keating et al., 2002), knowledge barriers such as professionals’ lack of training/understanding of cultural and faith issues and service-users lack of knowledge about mental health problems (McClean et al., 2003; Edge and MacKian, 2010; Faulkner, 2014; Islam et al., 2015, Memon et al.,

2016) and material barriers, which refer to lack of resources including treatment options and use of interpreters (Memon et al., 2016; Barron, 2010; Edge and MacKian 2010). These findings further stimulated my interest in attempting to open the “black box” (Bradby, 2010, p. 1) of institutional racism by examining the potential relationship between social worker AMHPs and institutional processes that lead to the disproportionate compulsory detention of Black people under the MHA.

According to Maxwell, (2012, p. 8) there is “the assumption that a person’s standpoint or perspective influences the way a problem is conceptualised or constructed.” Smith (1987), one of the originators of standpoint theory, uses the concept of standpoint to emphasise that what one knows is influenced by where one stands (one’s subject position) in society. Smith (1987) asserts that we see the world as we actually experience it, and what we know of the world and of the ‘other’ is conditional on that location (Smith 1987). However, Smith’s assertion is not that we cannot look at the world in any way other than from our given standpoint. Rather, her point is that (1) no two people have exactly the same standpoint; (2) we must not take the standpoint from which we speak for granted and (3) no one can have complete, objective knowledge. Instead, one must acknowledge and recognise it and be reflexive about it. According to Smith (2005, p. 10), our situated, everyday experience should serve as a “point of entry” of investigation.

Collins (1998, 1990, 2016) extends the ideas of Dorothy Smith by elucidating the particular epistemological standpoint of Black women. Collins however, does not simply add the idea of ‘race’ to Smith’s framework of standpoint theory. Rather, Collins highlights the ‘intersecting’ nature of a multiplicity of statuses for example: class, gender, race, ethnicity, sexual orientation and nationality - that make up our standpoint.

I came to the research project as a social worker with a professional mandate for social justice and anti-oppressive practice, particularly with marginalised individuals and communities. I am also a woman of Black Caribbean ethnicity. Thus, I came to the research with a standpoint. This standpoint grapples with the inherent competing tensions within social work of carrying out dual roles of control agent and change catalyst. It accepts that in certain circumstances detention under the MHA is the most appropriate way of providing care and medical treatment to meet the needs of a person. This standpoint also acknowledges that, in some cases, the compulsory detention of a person in hospital is due to a failure by agencies to respond effectively and earlier before hospitalisation becomes the solution. It recognises that people from Black ethnic backgrounds – specifically Black Caribbean men are overrepresented in their local detained populations and are more likely to be detained under the MHA than those in any other ethnic group in Britain. Black people are also more likely to experience a coercive pathway into mental health services. As a Black Caribbean woman living in Britain, I am acutely aware that I belong to a marginalised ethnic group which continues to receive differential treatment coming into contact with mental health services. Collins (1998, pp. 48-49) maintains that Black women “come to voice” and break the silence of oppression by drawing both from their own experiences and from the “collective secret knowledge generated by groups on either side of power.”

My standpoint influenced the evolution of the research project, impacting on the questions I asked, the choice of focus on AMHP participants, the design of the research, my analysis of the data and presentation of it. Notwithstanding the recognition of my role as a social worker and also a member of the marginalised ethnic group being investigated in this research, it is important to note that I strived to apply the research methods diligently, aware of the need to apply my skills in social research to my field of practice. Therefore, recognising and highlighting the fluid and dynamic implications of being a researcher, practitioner and ‘the oppressed’ owns up to the indisputable positionality involved in the research study by implication of my practitioner and personal standpoint. Notwithstanding, I make clear that this did not mean that my practitioner and personal identity was privileged over the need to apply my knowledge and skills as a researcher.

3.4 Ontological and epistemological considerations

According to Scotland (2012), methodology is the strategy or plan of action that informs the researcher’s choice and application of research method(s). It is underpinned by the researcher’s ontological and epistemological assumptions (Guba & Lincoln, 1994; Crotty, 1998) and concerned with the “why, what, from where, when and how data is collected and analysed” (Scotland, 2012, p. 9). Ontological assumptions are based on what a researcher believes constitutes reality (Crotty, 1998; Scotland, 2012). Crotty (1998, p. 3) asserts, “ontology is concerned with what is, with the nature of existence, with the structure of reality as such.” On the other hand, epistemological assumptions are about “how we know what we know” (Crotty, 1998, p. 8), and are based upon “how knowledge is created, acquired and communicated” (Scotland, 2012, p. 9).

I position myself as a critical realist (Houston, 2010; Morén & Blom, 2003; Oliver, 2012). The precepts of critical realism align with social work's central tension of care and control, vision of emancipation, and focus on marginalised groups (Oliver, 2012). Additionally, a critical realist approach potentially meets the requirements for evidence-based social work practice (Oliver, 2012). This also points to the understanding of social constructionism inherent in IE (Prodingler & Turner, 2013). This is because critical realists see people as active in constructing their own world, while also constrained and shaped by structures that have real effects (Sayer, 2010). A critical realist accepts an objective reality lies beyond ideas and concepts, potentially explaining why particular social problems arise and generating practical and emancipatory outcomes. I am interested in ethnic disparities in rates of compulsory detention under the MHA and the phenomena of overrepresentation as it relates to the disproportionate detention of Black service-users. In order to identify the structures that underpin these disparities, there are certain ontological and epistemological assumptions I need to hold.

For example, to conceptualise the project in the first instance, I relied upon the critical realist assumption of ontological realism that is, the assumption that a real world exists, independently of my own perceptions, theories and constructions (Maxwell, 2012). I acknowledged that regardless of my perceptions (or anyone

else's perceptions) of 'ethnicity,' there are disparities in the compulsory detention rates under the MHA for those who identify themselves (or are indeed identified) as Black. This assumption also holds that it is possible to capture data that can evidence these disparities concretely.

In deciding how to identify these disparities and structures, I drew upon the critical realist epistemological assumptions of constructivism that is, the assumption that a person's standpoint or perspective influences the way a problem is conceptualised or constructed (Maxwell, 2012). Therefore, in order to make sense of the nature of ethnic disparities in rates of compulsory detention under the MHA, it was important to draw on multiple perspectives/sources of data such as: MHA statistics; service-user testimonies; government reports; interviews and observations with social worker AMHPs and empirical research. In this way, I was able to capture a more complex picture of the phenomenon of ethnic disproportionality in compulsory detention under the MHA.

3.5 Qualitative research methods

This study employed a qualitative design method. A qualitative inquiry and analysis are more appropriate to achieve this study's aims and objectives in contrast to a quantitative methodology where data is presented numerically. Further, as little research exists on the research topic, a qualitative approach is fitting for this study. According to Heppner et al. (1999), because qualitative methodology uses individual experience, subjective interpretation and context, this offers a high level of internal validity to research claims, however it raises issues of uncertainty about external validity and generalisability of findings.

There are advantages to adopting qualitative methodologies for social research. Denzin and Lincoln (2008, p. 4) assert, "qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them." Bell (1993) argues that by adopting a qualitative perspective, researchers are better able to understand participants' perceptions of the world, therefore insight rather than statistical analysis is sought. In the field of health and social services, qualitative research has been used to describe many kinds of complex settings and complex interactions. These include interactions between service-users and professional groups and organisations (Denzin & Lincoln, 2008).

3.6 Critical research

Within this qualitative study, my critical framework lends itself to using critical research methodology. Many scholars maintain that theory and methodology are intimately linked (Peirce, 1995; Collins & Stockton, 2018; Leeming, 2018). This intimate relationship formulates the types of questions and assumptions made, it influences the methods and approaches used, and frames the results achieved.

There are a number of common tenets in critical research methodologies namely: to explore the relationship between structural/macro forces and human activity for the purpose of social change; to use individuals'

lived experience as a primary source of data; research must be located within historical context; marginalisation is produced and maintained by unequal power relations; and no research can claim to be objective (Peirce, 1995; King & Brooks, 2017; Cresswell & Cresswell, 2018; Denzin & Lincoln, 2018; Gray, 2018).

These tenets fit well with my research area. I am interested in how institutional forces shape how AMHPs' carry out sectioning processes with Black service-users. Sources and processes of overrepresentation, disproportionality, and social injustice should be of central importance to social work. Areas of practice and work with marginalised populations should require social work to reconsider its role not only in the processes leading to the involuntary detention of Black people but also in the prevention of those processes. In essence, by looking at the sources of and outcomes of overrepresentation rates, instead of the personal characteristics of those trapped within its web, this study seeks to map and explain what actually happens during sectioning processes of Black service-users, revealing any anomalies between institutional policies and actual practice. This approach aligns with social work's mandate for social justice as reflected in the key principles of the code of ethics of the British Association of Social Workers (BASW, 2015: 2.2).

Further, the critical literature supports the perspective that marginalisation is produced and maintained to perpetuate existing socio-political interests. For over two decades scholars have argued that social work's mandate of social justice, particularly for those who are marginalised has been silenced in the literature (Abramovitz, 1998; Finn & Jacobson, 2003; Rothman & Mizrahi, 2014). Longres and Scanlon (2001) assert that social justice is sparse as a focus in social work research and O'Brien (2010) contends that social justice is still seen as distinct from direct practice. Social work education has been criticised for too frequently maintaining an illusion of neutrality, minimising critical examination of systems that affect individuals and focussing instead on depoliticised theories and micro-level research and methods (Clark, 2006; Karger & Hernandez, 2004; Rothman & Mizrahi, 2014).

Sewell (2012) argues that the relationship between racism, stress and mental ill health is well established in the literature. Manifestations of racism are varied but are all independently linked to negative health outcomes. It amounts to a disease predictor and can be interpersonal, institutional or systemic (Sewell, 2012). According to Karlsen (2002), even where mental health professionals are from BME backgrounds, the perception by BME service-users that the institution itself is imbued with intrinsic racism in its policies and decision-making can cause meaningful health problems.

I am therefore interested in interviewing people with lived involvement of decision-making processes regarding the compulsory detention of Black service-users under the MHA. These people will act as informants about contemporary social work processes. As a qualitative approach to research, a critical ethnography explicitly sets out to critique hegemony, oppression, and unequal power relations in order to foster social change thus, this approach is inherently political as well as pedagogical (Palmer & Caldas,

2015). In contrast to conventional ethnography, which describes what is, critical ethnography also asks what could be, in order to challenge implied power relationships and perceived social inequalities (Thomas, 1993; Palmer & Caldas, 2015). As such, critical ethnography aims not just to investigate, but also to communicate methods that research participants can themselves use to further their own awareness and action (Palmer & Caldas, 2015). This study which investigates the lived experiences of social worker AMHPs, validates participants' professional knowledge and experience, which can be potentially used as evidence-based practice and a reference point to inform future social work discourse.

As a type of critical research methodology, the features of critical ethnographies include an emphasis on lived experience, discourse, reflexivity, and social justice change (Thomas, 1993; Madison, 2020; Lune & Berg, 2016; Creswell & Poth, 2018). According to Thomas (1993), critical ethnographies originate with a starting point from empirically grounded evidence of social conditions and who is interviewed is determined by who can provide the best insider knowledge of those conditions. Discourse as a central focus for inquiry, is examined in order to unlock privileged meanings and access the “netherworld of mundane life to unblock alternative metaphors and meanings” (Thomas, 1993, p. 46). Creswell and Poth (2018, p. 93) describe the major components of a critical ethnography as “value-laden orientation, challenging the status quo and addressing concerns about power and control.” A critical ethnographer will examine issues of inequality, power, inequity, repression, hegemony and victimisation (Creswell & Poth, 2018). However, engaging in critical research is not without challenges. One challenge is the idea that critical research is a criticism of individuals who come into view in the research. This is certainly not the intention of this study. It is my understanding that critical researchers are usually concerned with understanding and exposing the taken for granted events and practices that constitute the social world we inhabit.

My research falls well within this area of critical ethnography. It relies on understanding AMHPs' lived experience with Black service-users and how their lived experience influences their own professional practice. I explore the implications their experience has for social work discourse and on my own reflexive stance in being transparent about how I heard and understood their narratives for the purpose of social change. Since I am interested in understanding social work practice from the perspective of individuals who can tell me about their experience, it makes sense for me to look to IE as both a theory and method. As a critical ethnography, IE forms a cornerstone for my methodological framework.

3.6.1 Deciding to use institutional ethnography

In the process of developing the research methodology for this study, alternative approaches were carefully considered before arriving at the chosen methodology. Various methodologies offer distinct strengths and applications, but their suitability depends on the specific research objectives, theoretical framework, and nature of the phenomena under study (Denzin & Lincoln, 2018). In considering alternative methodologies that could have been used instead of IE and the reasons for their potential rejection in certain research

contexts, it is important to explore different approaches that may have been considered but ultimately not chosen.

Initially, quantitative methods commonly used in the field of population health research were contemplated. These methods enable researchers to generate evidence-based insights that inform public health policies, interventions, and strategies aimed at improving the health and well-being of communities and populations (Jacobsen, 2020). Surveys and questionnaires for example, might have been employed to gather statistical data on institutional practices or investigate specific cause-and-effect relationships within institutional contexts. Similar to the criticisms of these approaches provided by Mykhalovskiy et al., (2008), these quantitative approaches were rejected as they made it difficult to situate and reconcile the broader social world in which I had been immersed for five years prior through my practice as a social worker and my previous my research into AMHP decision-making. This study aimed to delve deeply into underlying social processes and everyday interactions within institutions, which required more qualitative and immersive methods (Bryman, 2016). Moreover, the research objectives prioritised a qualitative understanding of lived experiences and interactions of AMHPs within institutions, which numerical data alone could not fully capture. The complexity of social phenomena within naturalistic settings, such as institutions (in this study local authorities), required a more nuanced methodological approach.

Given the complex and context-specific nature of the long-standing phenomena of ethnic disproportionality in detention rates under the MHA, it became apparent that a qualitative approach would be more suitable for exploring the complexity and depth of the research topic. Case study research (Yin, 2018) was considered as it offered the potential to focus on in-depth exploration of specific cases involving compulsory detention of Black service-users within their real-life context. However, case study methodology was rejected as this study aimed to uncover broader patterns and processes extending beyond specific cases. Similarly, historical research methodology (Seale, 2017), which involves studying past events and developments to understand their impact on present-day phenomena, was considered as it could have been employed to trace the evolution of institutional structures and practices over time. Historical research was rejected as this study's research objectives are primarily focused on examining contemporary institutional processes and their implications for AMHP decision-making in the present.

Ultimately, a decision was made to adopt an ethnographic approach as it could facilitate an in-depth exploration of institutional practices and their impact on AMHP experiences and decision-making within a specific setting. IE methodology (Smith, 2005) was specifically chosen for its capacity to uncover systemic and hidden aspects of institutional practices across multiple contexts preferred for achieving a more holistic understanding of institutional and social dynamics. IE methodology facilitates the provision of rich, contextual insights into the phenomena of ethnic disproportionality in detention rates, aligning closely with the research objectives and theoretical framework guiding this study. Therefore IE (Smith, 2005), with its emphasis on understanding real-world practices and social interactions, was deemed the most appropriate methodological approach for capturing the nuanced dynamics of institutional life of research participants

(social worker AMHPs). Additionally, IE's focus on "people's ordinary good knowledge of how things are put together in our everyday lives" (D. Smith, 2006, p. 3) and their immediate effects, was deemed more suitable for addressing this study's research questions. Further, since there is no prescribed way to conduct research using IE, there was opportunity to make adaptations for the purposes of this study and to infuse creativity in fieldwork and analysis.

Previous IE studies aimed at eschewing ideological and deterministic accounts of how things happen, provided striking examples of the capability of IE to reveal concealed social dynamics and offer detailed, contextual insights into phenomena of interests similar to the research aims and theoretical framework guiding this study. For example, Pence's (1997, 2001) study from the standpoint of women who were survivors of domestic violence in Duluth, Minnesota. The study was an investigation of the work practices involved in reporting acts of domestic violence against women in Duluth. Pence (1997) found that women's experience with domestic violence was not accurately recorded in reports that documented these events. Women's experiences were summarised in ways that did not reflect what actually happened to them through violence in their home. Pence describes "processing interchanges" (De Vault & McCoy, 2006, pp. 30-31) as the reason for the inaccurate accounts of women's experiences. Pence's research contributed to the implementation of programme and policy changes in the interest of women which were based on the knowledge of the root causes of what were the issues for women. Examining the methods and findings of practical examples of IE found in studies by Diamond (1992), Pence (1997) and Rankin and Campbell (2006), captured my attention in IE's application as a methodological approach used by researchers in the areas of health and social interventions (DeVault & McCoy, 2004, p. 754). IE allows for a theoretically informed, albeit critical, lens to explore why there are large gaps between what is intended to happen (in policy) during AMHP decision-making processes and what actually happens in practice.

In summary, while alternative methodologies offered unique strengths and applications, they were rejected in favour of IE due to the latter's focus on uncovering the social organisation, coordination, and power dynamics within institutions through qualitative, ethnographic approaches. IE provides a unique lens for studying institutional phenomena from the perspective of those directly involved, aligning well with this study's objectives and seeking to understand lived experiences and interactions within complex institutional settings (Smith, 2005).

3.7 Institutional ethnography as a theory

IE is a feminist-oriented empirical approach to inquiry developed by Canadian sociologist Dorothy Smith (1987, 2005, 2006) that combines theory and method. Its purpose is to reveal how social and institutional processes have generalising effects on broad institutional structures and local practices (Proding, Rudman, & Shaw, 2013; Smith, 2005). It allows researchers to explore the systems and social relationships that structure what people do. Institutional ethnography is grounded in Marx's theory of a political economy and ethnomethodology – the ordering and ruling of what people do and how people know and do their

specific “work” as an entry point to study their position in social situations (Smith, 2005; Walby, 2007). Thus, it is implied that knowledge is socially constituted, therefore, whatever is brought into being is done so through the organising of what people do.

I was attracted to IE for its theoretical foundations. For example, IE is based on the ideas that peoples’ lives are shaped by access to resources and material conditions (for example, health services and education). People using IE subscribe to the idea that society is organised by access to knowledge and power; that is, certain kinds of institutional knowledge privilege some individuals and exclude others. A key tenet of IE is that institutions and organisational systems play an important role in the coordination of information, resource allocation, access to services, and everyday ‘doings’ of people they aim to serve (Campbell & Gregor, 2008; Smith, 1999, 2005).

IE has been well-accepted and used to make important evidence-based policy and practice changes. Researchers have used IE to investigate many different forms of social processes including the organisation of health care (Mykhalovskiy, 2003), education (Bechely, 2005) and nursing (Rankin, 2003). IE has been used in social work research to improve practice and inform policy for example, by describing processes used by social workers to produce a universalised professional form of knowledge through their day-to-day practices (De Montigny, 1995); the restructuring of Canada’s child welfare system (Parada, 1998) and lesbian and gay foster care and adoption (Hicks, 2009) and exploring the effectiveness of community treatment orders in mental health (Snow, 2015).

In particular, I was drawn to how IE could ‘make visible’ the social relations that shape and influence the everyday lives of a certain group of people (Smith, 1990). IE incorporates individuals, organisations/institutions, and relevant texts, including policies, procedures and manuals as part of the analysis (Mykhalovskiy, et al., 2008; Sinding, 2010). IE aims to produce evidence-based research that maps both human and textual/policy/institutional relations - in other words, to trace the relationships and kinds of communication that is facilitated between people, texts, and relevant institutions. Practically and materially speaking, I was drawn to a method of inquiry that was invested in multiple forms of data collection, including interviews, environmental observations and any relevant forms of text.

In the absence of conclusive evidence which explains the reason(s) for the persistent overrepresentation of Black service-users detained under the MHA, IE has the potential to be used in a way that provides comprehensive evidence that can be used to identify specific and clear recommendations for communities, professionals and policy makers.

3.7.1 Examining institutional ethnography's ontology and epistemology

I have invested significant time and energy in my attempt to understand what sets IE apart from other qualitative and applied research methodologies. During my initial reading and reflections on the philosophical and theoretical underpinnings of IE I recall moments of confusion, when it was stated at various points throughout my reading of the IE literature.

- IE is not a methodology! It is a method of enquiry
- IE is not limited to being qualitative research
- IE does not produce theories but is informed by theorists
- The distinctiveness of IE is in its attention to institutions

I concluded that there seems to be a layered understanding of the complexities of IE. I attempt here to summarise what I have come to understand about the ontology that informs how IE is defined. Smith (2005) has developed particular terms and ways of “seeing the world” that are unique to IE such as *ruling relations*, *trans-local* or *extra-local* and *problematic* (these terms are fully explained further down in this chapter). These IE ways of “seeing” are rooted in an ontology of the social (Smith, 2005) that resists and rejects the idea that one can hypothesize or theorise before or after they conduct IE research.

IE takes a particular interest in peoples' *actualities* over any conceptual ideas that might explain what is happening. There is a commitment to discovering what people actually do and how their doings are connected to other discoverable practices, circumstances, and processes. Furthermore, the researcher/ethnographer is only able to explore and discover within the very world that is being researched. Ontologically, IE comes from an understanding that peoples' lives, their particular experiences, can be traced to numerous social relations, including the organised coordination of people by institutional procedures. In other words, being able to understand how things happen the way they do requires first exploring peoples' actual activities, and also understanding that these activities are socially organised by forces that are largely unknown to the people whose experiences are of interest. Therefore, the focus is on how as opposed to hypothesizing or theorising why.

Smith's (2005) suggests that IE studies must pay particular attention to texts that coordinate or organise peoples' work. Texts that are “activated” by a reader can be powerful in their ability to influence how work is coordinated and carried out. The word “activated” is used to highlight that texts are only relevant when they are used or referenced by people; in other words, texts cannot do anything on their own. Early IE studies were epistemologically informed by scholars who took an interest in people who were subject to ruling relations, experiencing some form(s) of oppression. In most cases, scholars identified or worked closely with the people whose standpoint of oppression was the point of initial investigation. For example,

Diamond (1992) explored the social organisation of nursing home care from the standpoint of nursing assistants. Pence (1997) evidenced the social organisation of legal interventions for women in shelters who had experienced domestic violence. In the early 1990's, when IE was still considered a relatively new method of inquiry, there were also scholars who used IE as political activists, allies, or simply as fellow citizens who saw the emancipatory relevance of an IE inquiry. Some of these pioneers include G. Smith (1990) on the social organisation of policing the gay (male) community in Toronto, and DeVault (1991) on the work of women within their home.

In literature about IE, several authors talk about making an 'epistemological shift' (Campbell & Gregor, 2004; Kearney et al., 2018; 2019). Epistemological shift, refers to the way IE can radically shift our understanding of how things are organised. For example, in the field of mental health, this would be a shift from focusing on an individual's mental health diagnosis to understanding how their lived experiences are coordinated through largely invisible institutional processes. Deveau (2008) articulates what the epistemological shift looked like during her doctoral studies. She describes how people's everyday lives are experienced in a particular location, much like maps that have an arrow that marks 'You Are Here' - in a network of organised pathways connected to that very location (Campbell & Gregor, 2004). An IE project starts by identifying where someone's actual experience is in contradiction with ideological knowledge (the taken-for-granted assumptions of what is happening). This contradiction is called a *disjuncture*, an inconsistency, or an epistemological anomaly, which then gets framed into an IE study's 'problematic' (Smith, 1990).

3.7.2 Ethnography vs. Institutional Ethnography

Ethnography is distinct from IE. The main purpose of ethnography is cultural interpretation (Wolcott, 1990, 1999; Gobo, 2008; Allen 2017). In doing ethnography, an ethnographer actively participates in the group in order to gain an insider's perspective of the group and to have experiences similar to the group members. In writing ethnography, an ethnographer creates an account of the group based on this participation, interviews with group members, and an analysis of group documents and artifacts (Allen, 2017), whereas the aim of IE is interpretation of institutional processes that organise daily life (DeVault, 2006, 2013; Smith, 2005).

The assumptions of IE also differ from conventional ethnography because IE sees the everyday world as 'problematic' (D. Smith, 1990, Smith 2007). Methodologically, IE also differs from conventional ethnographic methods because the institutional ethnographer uses in-depth interviews to identify which texts to examine for the purpose of analysing the coordination of work, activities and experiences (Smith, 2006; DeVault, 2013). Methods for data collection in an IE include participant observation, interviews, and text work (Smith, 1995). 'Boss texts' is a term coined by Dorothy Smith (Griffith & Smith 2014) to acknowledge that some texts exert a powerful local influence over the everyday work lives of professionals. Boss texts are hierarchically positioned at or near the top guiding other text that carry out work of an

institution (Bisaillon, 2012). Text work involves a thorough analysis of boss texts (Griffith & Smith, 2014), documents and other materials.

I saw value in analysing, investigating and acquainting myself with other methodologies before settling on IE. I wanted to be certain that my methodology (or method) was practical and feasible for a three-year doctoral programme; had a compatible ontology and epistemology, and offered emancipatory possibilities embedded in or as part of the research dissemination at the end of the research project. After much reflection, I decided I would proceed with using IE for my doctoral study, building on the findings of my previous research and what I knew about best practices around BME mental health interventions and institutional processes that could affect the disproportionate detention of Black services-users under the MHA.

3.8 Institutional ethnography as a methodology

In order to better understand the role of social worker AMHPs, I am interested in examining their day-to-day work processes and hearing about their own experience(s) of the assessment and sectioning processes of Black service-users under the MHA. In short, since I am interested in understanding how social worker AMHPs engage in contemporary MHA assessments and sectioning processes, I have therefore chosen to use a research methodology that explores professional processes.

IE will inform this study's qualitative research methodology. Canadian sociologist Dorothy Smith formulated IE with her 1987 classic work "The Everyday World as Problematic: A Feminist Sociology". While often described as a feminist-oriented empirical approach to inquiry that combines theory and method (Smith, 1987, 2005, 2006). Smith (2005, 2007) also suggests that IE is a form of sociological epistemology and ontology that explores the 'local,' where people are at, to discover how the 'extra-local,' or institutional processes and texts beyond people's immediate awareness, shape peoples' everyday experience.

By focussing on institutional practices, IE studies pay particular attention to relevant printed and electronic texts, for example, forms and guidance, and policies that are activated by people that work within an institution. The ethnographic component reflects the way in which researchers start by exploring the everyday experiences of a particular group of people, mapping steps involved in their notion of 'work' – described by Smith (2006) as actions that take time, effort, and intent. In some ways, IE departs from the interest in generating theory, interpreting meaning, and conceptualising; instead, it examines social relations to explain what is actually happening and how it happens as it does. IE maintains the central tenet that people are "subjects of knowledge rather than the objects of study" (Smith, 2007, p. 409).

Importantly, IE reveals anomalies between institutional policies and actual practice, this approach has been useful in supporting organisations to evaluate their work processes, creating an environment in which organisation members are invested in implementing change (DeVault & McCoy, 2001; Smith, 2005). In this regard, IE has the capacity “to return knowledge to people...extending their ordinary knowledge of how things are put together” (Carroll, 2010, p. 24).

3.8.1 Key conceptualisations and terms in institutional ethnography

The key conceptualisations and terms used in the IE approach to inquiry will now be explained. Key concepts that IE relies upon include social relations and discourses, ruling relations, the problematic, and textual mediation.

IE begins with the actualities of daily life to reveal unacknowledged work, and how that work is situated in and shaped by social relations and discourses which are the purposeful arrangement and interplay of peoples’ everyday activities (Smith, 2005, 2006). Unacknowledged work is also the entry point where informants can talk about their involvement in organisational processes (Campbell & Gregor, 2004; DeVault & McCoy, 2001).

Informants’ everyday experience exposes the “problematic,” a key tenet/cornerstone of IE, which defines the major issue to be researched. Smith (2007) summarises the problematic or people’s experience of a problem as a result of institutional involvement. Given the statutory role of social worker AMHPs in sectioning processes under the MHA, the phenomenon of overrepresentation of Black people in compulsory detention is this study’s problematic. In accordance with Smith’s theory of social knowledge, all knowledge is influenced by the experiences of the knower and since IE serves to challenge oppression, the problematic is researched from the perspective of the people with the lived experience of the problematic (Campbell & Gregor, 2004).

IE also works to demystify processes that give rise to the marginalisation of specific groups. Campbell and Gregor (2004), use the act of using a bus pass to board a bus as an example to highlight this. While regular bus passengers would be familiar with the practice of showing their pass to the driver, an outsider might be confused at the accepted practice of some people gaining passage without presenting cash payment to the driver. IE explores seemingly accepted social relations at the “local” (people’s experience of boarding with a bus pass) and at the “extra local” organisational levels (the texts or policies that determine acquisition and use of bus passes) to “ruling relations” (Campbell & Gregor, 2004).

In IE ruling relations refer to the ways in which human action is organised, how institutional policies and procedures are integrated into daily work processes, which determine how work is coordinated and carried out (DeVault, 2006). IE examines those seemingly mysterious and tacit power dynamics behind all social relations. However, ruling relations go beyond the observance of regulations; according to Campbell and

Gregor (2004), ruling relations require knowledge and compliance in order for persons to proceed in a predetermined manner. Smith (2005) argues that ruling relations are not static, but are dynamic and always in flux, as systems change, ruling relations change. Campbell and Gregor (2004, p.41) assert, “Smith’s view is that it is through their active participation and in contributing their own knowledge of how to go about things that people are brought in line with ruling relations.” IE therefore attempts to investigate, discover and explain how “people’s everyday lives may be organised without their explicit awareness but still with their active involvement” (Campbell and Gregor, 2004, p.43).

To further explain the process of ruling relations, Smith (1987), highlights the role of ideology and discourse. Smith describes ideology not just as a set of beliefs, instead she views it as the way in which people think about how their own and neighbouring societies are socially structured and organised. Similarly, Smith argues that ideological concepts need to be challenged and questioned in order to identify their underlying expressions of social relations. An example of this can be found in Canadian researcher Brown’s (2006) qualitative study of parent experiences, which uses IE to explore how influential professional and administrative discourses and technologies infiltrate the everyday lives of mothers who are the subject of risk reduction strategies as government responses to child protection concerns. In her explanation of ideological ruling relations, Brown (2006) refers to the process of revealing the “dynamic ways in which the complex web of professional and institutional practices that organise modern capitalist society (such as government, education, business, and the law) contribute to ongoing struggle and oppression in many peoples’ lives” (p. 355).

In the context of this study, ruling relations occur outside of a social worker AMHPs’ personal choice and infiltrate daily work processes. For example, when an AMHP visits a service-user, the meeting, process, urgency, necessity, conversation, and purpose are predetermined by centrally produced policy and protocols. IE therefore offers an avenue to map how things occur in everyday practice and how they are connected reveals conceptualisations such as power, knowledge, hierarchy, and policy. Furthermore, ruling relations and organisational forms of authority are included in people’s discourse, and their descriptions of their experiences (Walby, 2007). For example, when a person states that they were ‘sectioned,’ the AMHP’s statutory role in the legal process of compulsory admission of a person to a psychiatric hospital is subsumed into the person’s description of their experience of being compulsory detained.

According to Smith (1987), the problematic and ruling relations are “textually mediated” through established procedures and required documentation. Moreover, Walby (2005) argues that the analysis of texts in IE produces “truth” and maintains surveillance processes. Thus, professional practices are governed by written guidelines and policies, management is illustrated through organisational chart structures and chains of command, and organisational priorities follow government policy and legislation.

3.8.2. Institutional ethnography as a method of enquiry

Once the problematic has been identified, key informants are interviewed. The purpose of interviewing is not to garner information about the informants themselves, but rather about ruling relations as played out in everyday occurrences. The IE research process is ongoing and unfolding, responding to each new discovery with new questions (Walby, 2007). Questions often arise out of the research process; each informant offers new information. The research does not study the informants; rather it gathers information about the problematic from the informants. As such there is often no set interview guide, rather each informant's story offers new layers to be explored with the next informant (Campbell & Gregor, 2004).

When interviewing informants, rather than theorise about possible assumptions (such as jargon or expressions) it is important to hear the expertise they describe about their experience: what exactly occurred, what was said and how did these events unfold. For instance, if an informant states that a person was detained, the researcher would ask for specific descriptions of what that actually looked like or how that actually transpired rather than rely on 'detained' as a shared conceptualisation (Campbell & Gregor, 2004).

3.8.3. Data Analysis in institutional ethnography

In IE researchers transcribe interviews and analyse data by looking for themes, topics, or reoccurring words. Unlike other qualitative methods, the data must be analysed in context and not separated and sorted. A guiding question to analysis is "what does this tell me about this setting or how this event happens?" (Campbell & Gregor, 2004, p. 85). This recursive style of analysis for institutional ethnographers reveals patterns that should demonstrate a clear and transparent flow from the data to the results, illustrating relations of ruling rather than simply making assertions and offering declarations of oppression. Analysis also requires that the researcher is confident in the research methodology, and the intended audience. Campbell and Gregor (2004, p. 67) argue that since IE's goal is emancipation of people who are marginalised, the "analytic discourse aims to unshackle comfortable ways of viewing the world."

Accordingly, analysis within IE also requires that data is allowed to speak without excluding what does not necessarily fit. In order to make it accessible to both professionals with a mandate for social justice and to marginalised peoples, the results should be free of complicated or exclusionary jargon. As aptly stated by Thomas (1993, pp. 63-64), the results should remain true to the data, to demonstrated evidence, and not move to a "wild orgy of verbal bloodletting in which the researcher moves from interpretation to yelling 'revolution' from the rooftop in the dark!"

Transcripts are not analysed by constructing the meanings through a theoretical framework, but rather by explaining the ruling relations that are imbedded but not necessarily obvious (Smith, 2005). Thomas (1993, p. 43) asserts that interpretation is therefore a "defamiliarisation process" where previously unchallenged concepts are reframed and alternative interpretations identified. Thomas (1993, p. 44) describes the

defamiliarisation process as when “stairwells are no longer just avenues for moving between floors but may be gender battlefields where women protect their space, bodies, composure, status and identity”.

In IE analytical maps are produced in order to conceptualise relationships between people’s actual experiences and institutional processes so that the researcher can then better visualise and, therefore, explain those relationships (Walby, 2007). In addition, conceptual maps can be produced for informants so they can increase their knowledge about their everyday world or so they can better make sense of their everyday world as organised by influential but hidden ruling relations (Smith, 2007).

3.9 Limitations of institutional ethnography

Similar to other methods of inquiry, IE has theoretical and methodological limitations. Walby (2007) has criticised Smith’s (2005, 2006) claims including that IE differs from conventional forms of sociological research, does not have a precise theoretical orientation and has a distinct method of analysis. Instead, Walby suggests that all social science research is aligned toward a specific theory or meta-theory.

For example, the assumption that the world provides a problematic is derived from critical ethnography and Marx’s ethnomethodology and political economy. Walby (2007) argues that viewing work as situated within ruling relations is grounded in Pierre Bourdieu’s and Michel Foucault’s theories of culture and power (Bourdieu, 1977; Foucault, 1979) and not a significant departure from sociology.

Inadequate attention to issues of rigour has also been identified by Walby (2007) as an area of concern in IE. According to Walby (2007) although IE is concerned with exploring relations of ruling, as a methodology, it has been less reflexive with its own relations of research such as data collection and analysis of results. Consequently, the institutional ethnographer is able to maintain considerable influence over how informants’ experience is presented, how data is interpreted and the analysis and presentation of results. Walby (2007) asserts that the lack of transparent and clear IE data analysis methods result in this approach, being “virtually indistinguishable from purportedly objectivist methods” (p. 1023). Walby (2007) argues that researchers must critique the social relations embedded in IE’s research approaches in order for the method to achieve maximum usefulness as a critical research strategy.

Although I appreciate Walby’s critique of IE as a social theory, the critique does not acknowledge the philosophical and theoretical underpinnings of IE as outlined by Smith (2005). Additionally, Walby’s critique of IE does not reflect the importance of the role of the researcher. According to Smith (2005), institutional ethnographers view people as the ‘experts’ in their own experience and activity but acknowledge that they do not necessarily see the more distant sites of coordination that organise and mediate their experiences. Therefore, analysing and communicating about those hierarchical organisational processes are, in fact, the primary task of the institutional ethnographer. It was evident in

my experiences during my dissertation for my Masters in Social Research that AMHPs were loosely aware of the ways in which organisational texts such as case notes which include demographic data and a ‘risk rating’ pertaining to individual service-users mediate the daily activities of their service and how those texts perpetuated particular practices that supported and limited choice and participation for Black people subject to sectioning processes under the MHA.

Contrary to Walby (2007), Campbell and Gregor (2002, p. 4) argue that IE methodology is able to withstand the standards of rigour of qualitative research by “employing the techniques in ways that explicate ruling relations.” Particularly, researchers’ ability to demonstrate how their procedures for arriving at their results align with their stated methodology determines the validity of the research (Campbell & Gregor, 2004). Additionally, transparency regarding the purpose, assumptions, and principles guiding the research, places accountability on the researcher in terms of the reliability of the results (Mauthner & Doucet, 2003; Walby, 2007). In essence, the institutional ethnographer addresses rigour by being transparent and true to the methodology.

Unless a researcher intends to enter into orthodoxy of practice, it is not only instinctive but also stimulating to think critically about the research methods we adopt. Nevertheless, I am intrigued by the paucity of published critiques of the methodological and theoretical approaches of Dorothy Smith’s IE. Based on her personal communication with fellow researchers, Bisailon (2012, p. 283) asserts, “most of the critiques of institutional ethnography are thought to circulate by word of mouth. People who don’t like it simply ignore it since it isn’t a dominant approach that is easy to do.”

3.9.1 Addressing the limitations of IE

To address the limitations associated with IE, a range of strategic approaches were implemented throughout the research process. Rather than focusing exclusively on a singular institutional context, purposeful sampling was employed to select two specific local authority research sites based on predefined criteria such as geographic variation and demographic diversity (Patton, 2002). This approach ensured that the study sample reflected the heterogeneity of the population and participant experiences, thereby enhancing the transferability of findings. Diversifying the sampling strategy provided in-depth insights into contextual factors that influence AMHP detention decision-making with Black service-users. Exploring different research settings enriched the understanding of how location and demographic variables shaped experiences, behaviours, or outcomes for participants and service-users.

Methodological rigour was a critical consideration in addressing challenges associated with IE (Walby, 2007). Rigorous data collection methods, including in-depth interviews, were employed alongside the integration of multiple data sources such as textual documents and observational notes from the conducted interviews (Denzin & Lincoln, 2011). The integration of diverse data sources and the analysis and synthesis within a coherent theoretical framework required methodological rigour and careful attention to detail.

Systematic and thorough data collection techniques were employed to ensure comprehensive exploration of institutional dynamics (Campbell & Gregor, 2004).

Establishing access and building rapport with participants were essential aspects of the research process. Overcoming access barriers and fostering relationships with key stakeholders required proactive engagement with gatekeepers. Transparency was demonstrated through adherence to ethical guidelines and fostering trust through ongoing communication and collaboration with participants.

Like other qualitative methods, IE is susceptible to researcher subjectivity and bias (Mauthner & Doucet, 2003; Walby, 2007). Researchers' interpretations of data and interactions with participants can influence findings, highlighting the importance of reflexivity and transparency in reporting research processes and outcomes. To mitigate researcher bias, reflexive practices were embraced throughout the research process by critically examining personal positions, perspectives, and assumptions to enhance the validity and credibility of study findings.

A strong theoretical grounding was essential for IE. Articulating the theoretical framework explicitly and aligning the analytical approach with established sociological theories, such as cultural identity theory (Collier & Thomas, 1988), ensured conceptual clarity and theoretical coherence in the research design and analysis.

By adopting these strategic approaches, the limitations of IE were addressed, thereby enhancing the validity, rigour, and impact of the research in uncovering hidden social processes and power dynamics within AMHP decision-making processes.

3.10 Instruments of this institutional ethnography study

In this section, I provide a detailed overview of the project's ethnographic fieldwork. I aim to provide enough information about how the research was conducted to make the significance of my findings to be apparent (Wolcott 2009). The sections that follow provide a description of the project's ethical considerations, research strategy, setting and participants, data sources, collection activities, strategy for data analysis. I also examine fieldwork challenges that I encountered and how I addressed these in the research and what I learned from them.

3.10.1 Ethical approval

Ethical approval for all aspects of this study was sought and received from the National Health Service's Health Research Authority, Research Ethics Committee (REC) [see Appendix A for ethical approval] Ethical considerations were guided by professional codes of ethics, the British Sociological Association's code of ethical practice (www.britisoc.org, 2017) and University of York's data management policy (www.york.ac.uk, 2018). This REC reviewed this study, (REC reference number 20/WM/0273) in October

2020. The members of the REC gave a favourable ethical opinion of this study on the basis described in the Integrated Research Application System (IRAS) application form, protocol and supporting documentation.

3.10.2 Ethical and regulatory considerations

To address the potential ethical and regulatory risks associated with this study, the following mitigation strategies were implemented:

Sensitivity of the Subject

Given the nature of the study, it was unlikely that participants would suffer harm as the focus was not on sensitive topics such as bereavement or abuse. However, some participants may have experienced emotional distress when discussing challenging work experiences or issues around race and ethnicity. To mitigate these risks:

- a) Participants were clearly informed of the study's nature and voluntary participation, emphasising that there were no right or wrong answers. The researcher aimed to build rapport to maintain a friendly yet professional tone during discussions.
- b) Participants were informed of their right to refuse to answer questions or stop the interview at any time if they felt uncomfortable or distressed. Debriefing sessions were offered post-interview to address concerns informally.
- c) Interview topics were designed to avoid direct questions about upsetting experiences, allowing participants to discuss difficult topics on their own terms if desired (e.g., "What does it mean to you to be an approved mental health professional?").

Confidentiality

Confidentiality was crucial due to the sensitive nature of the interviews with practicing social worker AMHPs. Mitigation strategies included:

- a) Ensuring interviews took place in private settings where third parties were not present, arranged with participants and their line managers.
- b) Anonymising all collected data to prevent identification of participants or service-users in any reports or publications.
- c) Participants were asked to anonymise service-users when providing practice examples. Audio recordings were only accessible to the researcher and permanently deleted post-study.

Informed Consent

Steps were taken to ensure full, informed, and voluntary consent from all participants:

- a) Participants were provided with comprehensive information about the research aims and had ample time to consider participation before deciding.
- b) It was emphasised that participation was voluntary and participants could withdraw at any time, even after participation, with their data destroyed upon withdrawal.
- c) Participants were informed of their right to decline answering any questions without explanation or consequence.

Legal Disclosures

Participants were informed of confidentiality boundaries, particularly regarding disclosures requiring further action:

- a) Participants were reminded of confidentiality limits, especially concerning intentions to harm themselves or others. Line managers and PhD supervisors would be notified if further action was legally required.

Data Protection

To ensure data confidentiality post-interview:

- a) All interviews and data files were securely stored, encrypted, and password protected in accordance with the Data Protection Act 2018 and university policies.
- b) Zoom recordings were managed compliantly with GDPR regulations, ensuring restricted access and immediate deletion post-transcription.
- c) A logical yet straightforward folder structure was adopted for data organisation, with contingency plans in place for any suspected data loss.

In summary, rigorous ethical considerations and mitigation strategies were implemented throughout the study to protect participant confidentiality, ensure informed consent, and address any potential emotional or privacy-related risks associated with the research. These measures upheld ethical standards and safeguarded the integrity of the study's findings.

3.10.3 Research Strategy

This study is informed by two main data sources: human and textual sources developed, organised and used by people. IE provides a specific method to link AMHPs' everyday work with institutional structures that shape practice. Although ethnographic practice in general provides a framework for rich description of the contexts of everyday life, the aim of IE is not thick description; rather, the aim is to expose the articulation of the activities of everyday life with institutional power relations. Methods of data collection for this study included audio-recorded in-depth semi-structured interviews with participants; field notes that incorporate a researcher journal, along with the examination of selected texts related to the AMHPs everyday work.

3.11 This study's informants

Social worker approved mental health professionals (AMHPs) are this study's informants. According to Smith (2005, p. 31) it is the participants' standpoints which "organise the direction of the ethnographer's investigation." AMHPs play an integral part in the legal process of compulsory admission to a psychiatric hospital (Davidson et al., 2016). The role of the AMHP is "to provide an independent decision about whether or not there are alternatives to detention under the MHA, seeking the least restrictive alternative and bringing a social perspective to bear on their decision" (DoH, 2015, p. 23). AMHPs exercise their own judgment, based on social and medical evidence, when deciding whether to apply for people to be detained under the MHA. It can be argued that AMHPs are directly involved in the disproportionate detention of Black people as they make the final decision as to whether someone should be detained or not. This study is concerned with what is troubling and experienced as contradictory for informants in relation to seeking the least restrictive alternative and bringing a social perspective to bear on their decision.

Demographic data collected by Skills for Care and the DHSC (Skills for Care, 2022) shows that overall, there are an estimated 3,800 AMHPs in England, of which 94 percent are social workers. The majority of AMHPs were employed in the local authority sector (77 percent), 16 percent were employed in the NHS and 6 percent agency and freelance. AMHPs are more likely to be female (75 percent), over 45 years old (61 percent), White (77 percent) and British (89 percent). The average experience in current role for an AMHP was 7 years (Skills for Care, 2022).

For this study, thirty-one social worker AMHPs gave interviews where they spoke candidly about their experiences of conducting MHA assessments with Black and/or Minority Ethnic people. A thematic analysis interpreted the four main work phases in progressing an MHA assessment from the initial referral to post assessment requirements. There were explicit references to the ethnicity of service-users by participants, reflecting rich and varied accounts of conducting MHA assessments with Black and/or Minority Ethnic service-users detained under S3 MHA. Participant interviews highlighted professionals' conceptualisation and assessment of risk, socioeconomic circumstances of the person being assessed, social capital and proximity of relatives, police involvement in the detention process and service-user engagement

as prominent factors in AMHP decision-making. These factors are also highlighted by the Race Equality Foundation (Bignall et al., 2019; Barnett et al., 2019) and provide a critical insight into this study's problematic - the longstanding phenomena of the disproportionate compulsory detention of Black people under the MHA.

Notwithstanding the ambitions outlined in 'Reforming the Mental Health Act White Paper' (DHSC, 2021) to remedy ethnic inequalities, longstanding ethnic disparities call attention to the impact of institutional practices, policies and procedures which result in consistent differential outcomes for people from Black ethnic groups. It is therefore important to have a deeper understanding of the nuances and processes within contemporary MHA assessments, and opportunities for AMHPs to seek the least restrictive alternative and social perspective whilst carrying out their statutory duties under the MHA (DoH, 2015). In essence, the AMHP holds the balance of power in deciding after all circumstances of a case are considered, that compulsory detention in a psychiatric hospital is the most appropriate way of providing the required care and medical treatment to meet the needs of the person on completion of an MHA assessment.

Investigating the reasons for the persistent disproportionate compulsory detention of Black people under the MHA and ethnic inequalities in mental health generally, are complex and varied and therefore not amendable to a single approach or solution. It is within this context that this thesis has called attention to social worker AMHPs who are this study's standpoint informants/research participants and provide personal accounts of the decision-making processes associated with the four main stages in progressing an MHA assessment from the initial referral to the decision to detain or not detain under the MHA. This empirically informed enquiry describes the MHA assessment work process as consisting of a myriad of events, activities and practices occurring over time and place. A corrective insight is offered to counter other "official" and "ideological" accounts of what happens during and as a result of an MHA assessment. Thus, a realistic and just account of the MHA assessment and associated work processes is produced. In addition, the textual basis of AMHP work is analysed which is composed of a number of texts such as: Richard Jones Mental Health Act Manual (Jones, 2022), the MHA Code of Practice (DHSC, 2015a); the MHA reference guide (DHSC, 2015b) and the case file and accompanying notes prepared by the AMHP which are among the most important set of documents used by informants.

By examining the activities informants are drawn into during the decision-making process and how they interact with the complexities of the MHA assessment and interdisciplinary working, provided the empirical basis for examining experiences within these complexes. This includes informants' experiences of MHA assessments with people from Black ethnic groups as well as the role of the nearest relative, S12 doctors and doctors with previous acquaintance, police and conveyance providers who all come into view for critical consideration. This is because informants revealed decision-making processes were sometimes impacted by these interactions.

3.12 Research settings and participants

There are an estimated 3,730 AMHPs in England, of which 94 percent are social workers, 5 percent are registered nurses and less than 1 percent occupational therapists and psychologists (Skills for Care, 2022). As social worker AMHPs make up the vast majority of the AMHP workforce, purposive sampling was used to recruit social worker AMHPs from across two separate local authorities (LAs) in the North of England in order to explore experiences across different LA areas. Thirty-one AMHPs agreed to participate in this study. Research interviews were conducted over a period of fifty-two weeks. Purposive sampling was used as it makes practical judgments about selecting cases and identifying participants that provide insight into issues of central importance to the research (Emmel, 2013). Additionally, samples that are purposive provide richly-textured information, relevant to the phenomenon under investigation (Luborsky & Rubinstein, 1995).

Choosing a suitable sample size in qualitative research is an area of conceptual debate and practical uncertainty (Vasileiou et al., 2018; Morse, 2000). Creswell and Creswell (2018) estimate between ten and fifty participants as being sufficient depending on the type of research and research question. Ritchie et al. (2003) recommend that studies utilising individual interviews with participants conduct no more than 50 interviews so that researchers are able to manage the complexity of the analytic task. Whereas Lincoln and Guba (1985) proposed that sample size determination be guided by the criterion of ‘informational redundancy’ that is, sampling can be terminated when no new information is elicited by sampling more units.

Participants were homogenous in terms of occupation as they were all practising social worker AMHPs with experience of conducting MHA assessments and sectioning processes involving Black and/or BME service-users. The following inclusion and exclusion criteria were applied to participants:

3.12.1 Inclusion Criteria

1. Registered social workers who are practising AMHPs.
2. AMHPs with experience working directly with BME service users including MHA assessments.
3. AMHPs who have a minimum of one year experience in their role to ensure a depth of understanding and expertise.

3.12.2 Exclusion Criteria

1. Social workers who are not AMHPs or are not registered with Social Work England.
2. AMHPs without direct experience working with BME service users.
3. AMHPs who have limited or no involvement in conducting MHA assessments for BME individuals.
4. AMHPs with less than one year of experience in their role to ensure a sufficient level of expertise.

5. AMHPs working in non mental health related roles or settings that do not align with the scope of the study.

These criteria aimed to target a specific group of social worker AMHPs who have relevant expertise and experience in conducting MHA assessments with Black and Minority Ethnic people. By clearly defining these criteria, the study ensured the selection of participants who met the research objectives and could contribute meaningfully to the research outcomes.

3.12.3 Demographic of participants and research settings

Participants

I sent an introductory email to social work AMHPs inviting them to express an interest in finding out more about participating in the research. Access to AMHPs' emails was provided through intermediary senior managers in the relevant areas, introducing me to potential participants. The email provided full information regarding the study and consent forms were also sent, with the caveat that information about the research and consent would be further formally explained and confirmed prior to interview. Participants were advised at the outset of their right to withdraw at any time without explanation.

The information sheet (Appendix D) and consent form (Appendix E) were provided in both paper form and via email to the participants. Those wishing to participate or to seek further information were invited to contact me by phone, email or in person according to their preference.

The demographic profile of the research participants predominantly comprised individuals who self-identified as White British, with a total of 25 participants. The remaining 6 participants represented a mix of Black and Minority Ethnic (BME) groups and other White ethnic backgrounds. Due to the limited number of participants from non-White British backgrounds, detailed demographic data that might identify specific individuals is not disclosed. This limitation underscores the necessity of maintaining confidentiality and anonymity, particularly for minority groups within the study cohort. Despite the relatively small sample size of non-White British participants, their perspectives contribute valuable insights to the study, highlighting the significance of diversity and representation in this study.

In relation to work experience, participants demonstrated diverse lengths of service as AMHPs, with 11 participants having practiced in this role for over 15 years. The remaining participants had varying lengths of practice ranging from 1 to 15 years. Notably, 4 participants had over 20 years of experience, having previously worked as approved social workers before the role was renamed in 2008. This blend of knowledge and experience in both AMHP and social work practice proved invaluable in capturing a diverse array of insights and experiences from the participants.

Research settings

Due to the confidential and sensitive nature of AMHP work and as part of the ethical and regulatory considerations of this research, it is imperative to maintain strict confidentiality and protect the identity of participants and the institutions involved. This includes not disclosing the exact location of research settings, such as the specific local authorities where participants practice, to safeguard confidentiality and uphold ethical considerations. By withholding specific details about the research settings, researchers ensure that individual participants and their associated institutions remain anonymous. This is crucial for maintaining trust and fostering a safe environment for participants to share their experiences openly without fear of repercussions or breaches of confidentiality.

Furthermore, IE often focuses on systemic or structural issues within institutions, rather than individual characteristics or behaviours (Smith, 2005). Therefore, the emphasis is on understanding broader patterns and processes that transcend specific locations, while still respecting the privacy and confidentiality of participants and institutions. Therefore withholding the exact location of research settings in this study is a precautionary measure aimed at safeguarding participant confidentiality, preserving institutional anonymity, and upholding ethical standards in research practice.

Choosing two geographically different research settings was crucial in this IE study for several reasons. Firstly, geographic variation allowed the researcher to capture diverse experiences and perspectives within different institutional contexts. This variation provides a broader and more nuanced understanding of how institutional practices unfold and are experienced within different localities. By selecting research sites that differ geographically, the researcher can examine how specific geographical, cultural, and socio-economic factors influence institutional processes and outcomes. For example, differences in local policies, community demographics, and resource allocation can shape how institutions operate and interact with individuals and communities.

Secondly, conducting research in multiple settings enhances the transferability and generalisability of findings. By comparing and contrasting findings across different geographical contexts, the researcher can identify common patterns or variations in institutional practices that transcend specific locations. This comparative approach strengthens the validity and robustness of the research findings.

Demographic data on local authority A and B were obtained through the 2021 census (ons.gov.uk, 2022) and local government reports. Local authority A, is situated in a city in the north of England. The city's demographic makeup reflects a blend of ethnicities, ages, and socio-economic backgrounds. Ethnically, the city is characterised by its diverse population. The largest ethnic group is White British which comprises 85 percent of the population, accounting for the majority of residents. Additionally, the city is home to significant Black, Asian, and Minority Ethnic communities, including individuals of Black African, Black

Caribbean, Pakistani, Indian, Bangladeshi, and other ethnic backgrounds comprising 11 percent of the city's population.

The city has a relatively young population compared to other parts of the UK, with a substantial proportion of residents falling within the working-age bracket, the average age is 36 years old. Socio-economically, the city displays a mix of affluence and deprivation. While certain areas of the city are affluent and prosperous, others face socio-economic challenges such as unemployment, poverty, and inequality.

Local authority B, is situated in a city in the south of England, and presents a diverse and dynamic demographic landscape. The ethnic makeup is notably diverse, encompassing a blend of ethnicities and backgrounds. White British is the largest ethnic group, constituting around 71 percent of the population. The BME population collectively accounts for approximately 19 percent of the city's population. The BME population comprises individuals from African, Caribbean, South Asian, and other ethnic backgrounds contributing to the city's multicultural character.

Age distribution in the city where local authority B is located leans towards a youthful demographic, with a notable representation of residents falling within the working-age bracket and the average age being 30 years. However, there is also a growing population of older adults, reflective of broader demographic trends observed across the UK.

In terms of income and socioeconomic status, there is a mix of affluence and socio-economic challenges. While certain areas of the city are affluent, others grapple with income inequality and deprivation, underscoring the socio-economic diversity within its population. Fifteen percent of people living in local authority B are in areas of high deprivation. The estimated level of mental health need amongst the adult population across the city is 20 percent. There are a variety of faiths and beliefs. Christianity is the dominant religion, but there are also substantial Muslim, Hindu, Sikh, and Jewish communities, among others, highlighting religious pluralism.

3.13 Interviews

According to Kvale (1996), interviews are conversations that are designed to capture the interviewee's perspective or world-view on a particular topic. Interviews are the most commonly used method of data collection within social research (Edwards, O'Mahoney & Vincent, 2014). There are three main types of interviews: structured, unstructured and semi-structured (Alshenqeeti, 2014). Semi-structured interviews were used in this study as institutional ethnographers often utilise semi-structured, open-ended interviews in order to learn 'how things work,' that is, understanding the coordination of activity and particular components of ruling relationships that emerge throughout the research process (DeVault & McCoy, 2001; Townsend, 1996).

In IE, informal interviews, the conversations that occur outside a scheduled formal interview are also important to understand what people are doing, why they do it in a particular way, what documents and policies determine what they do, when they do it, and where they do it (DeVault & McCoy, 2001). DeVault and McCoy (2001) assert, “informal” on-the-spot interviewing can be combined later with “formal” or planned interviews, in which the researcher brings to the longer interview a set of questions or topics based on the “early observation and talk” (pp. 756-757). Interviewing, sometimes referred to as co-investigation in IE, allows participants to discuss their work and related issues in a less directed but discursive manner (Smith, 2006). The depth with which researchers understand their interviewees’ perspective can be increased using semi-structured interviews (Rubin & Rubin, 2005). In light of the complex and sensitive nature of the research topic, and the ethnographic component of the research, utilising other data collection methods where it is not possible to ask interviewees follow-up questions, such as questionnaires and surveys, would not have been suitable as those methods are unable to capture the depth of the interviewees’ perspectives. Semi-structured interviews were therefore used as it is more likely to be effective in highlighting the institutional processes that underpin the ethnic disparities in detention rates under the MHA; AMHPs perspectives on why these disparities occur; areas of good practice that address these disparities; areas for development and recommendations for potential solutions.

Interviews lasted an average of 60 minutes. Due to the social distancing restrictions brought about by the COVID-19 pandemic, most participants were working from home therefore, interviews were conducted virtually via Zoom videoconferencing at a date and time agreed to by the participant. Interviews were later transcribed verbatim by the researcher and included as part of the field notes (excerpt of interview transcript Appendix I). An interview guide for semi-structured interviews with participants is included in Appendix H and an interview schedule in Appendix G.

3.14 Texts

Smith (2006) highlighted the importance of texts in understanding the way that the social world is organised. IE recognises that text-based forms of knowledge and discursive social practices are central to organising what people do (DeVault & McCoy, 2001). I therefore accorded prominence to locating texts and documents relevant to the law and policy of the sectioning processes under the MHA in the lead up to fieldwork. These included the Mental Health Act Manual, The Mental Health Act Code of Practice (DoH, 2015) and the reference Guide to the Mental Health Act (pictured below) and a blank Adult Social Care AMHP referral and assessment form. I learned that there were a number of texts that the government has created in relation to sectioning processes under the MHA. The goal in this textual review was to build understandings about the work processes in which these texts are located as they are brought into being and used in people’s work practices.



Figure 6. 'Boss Texts' used to coordinate and organise AMHP work activities

Texts as shown in Figure 6, offered a lens through which I was able to examine the organisation of work within the two AMHP services in local authority A and B. These texts were identified through informal and formal interviews with participants (DeVault, 2006; Smith, 2006; Townsend, 1996), as well as my prior knowledge as a social worker. Texts play an integral role in the social organisation of AMHPs' activities and they provide clues regarding the way activities are articulated to structures of power in the workplace and beyond. The AMHP coordinates the multiple activities that support sectioning processes under the MHA such as an assessment and arranging for two doctors to assess and agree that a person meets the criteria for detention under the MHA. When viewed in this way, texts become a vehicle for the concrete maintenance of this power differential between the service-user and AMHP, whether or not the AMHP or service-user perceives the relationship to be hierarchical. 'Ruling relations' is the concept that Smith (2006) uses to name the socially organised exercise of power that shapes people's actions and their lives. Texts are nearly always implicated in ruling relations, at least in contemporary societies.

I reviewed each text (Appendix K) and made notes of how the texts entered into and coordinated the actions of social worker AMHPs and service-users, in particular, the texts that exerted a powerful local influence over the everyday work lives of participants. Griffith and Smith (2014, p. 12) refer to these primary institutional documents and policies as "boss texts."

3.14.1 Trustworthiness and rigour

As a concept, rigour is perhaps best thought of in terms of the quality of the research process. As stated earlier in this chapter, to date, rigour is not an area that is clearly addressed within IE literature (Walby, 2007). This is compounded by the fact that demonstrating rigour when undertaking qualitative research is challenging because there is no accepted consensus about the standards by which such research should be judged (Rolfe, 2006). Despite this, researchers are expected to demonstrate trustworthiness and

methodological rigour in academic research, funding applications and publications. Researchers conducting quantitative studies use established and largely uncontested terms such as internal validity, reliability, objectivity and external validity (Krefting, 1991). In establishing trustworthiness, Lincoln and Guba (1985) created four stringent criteria in qualitative research, known as credibility, dependability, confirmability and transferability. These measures or standards of rigour fit well for me and speak to my need for ethical accountability in my chosen methodology. Accordingly, I have adapted these criteria by selecting strategies that applied to this study systematically. Table 3 illustrates how these strategies were adapted in this study.

Table 3 Key strategies in assessing trustworthiness and rigour in qualitative research adapted from Lincoln and Guba (1985)

Rigour Criteria	Purpose	Examples of techniques	Strategies to be applied in this study
Credibility	To establish confidence that the results (from the perspective of the participants) are true, credible and believable.	<ul style="list-style-type: none"> • Prolonged and varied engagement • Persistent observation • Triangulation • Participant checking/debriefing • Interview process and techniques 	<ul style="list-style-type: none"> • Spend an average of 8-10 weeks interviewing and engaging with participants in the local authority AMHP service • Interview until data saturation is achieved • All field notes properly recorded, transcribed and analysed • Conduct regular debriefing/follow-up sessions with informants
Transferability	To extend the degree to which the results can be generalised or transferred to other contexts or settings.	<ul style="list-style-type: none"> • Purposeful sampling • Thick descriptions 	<ul style="list-style-type: none"> • Adopt purposive sampling techniques
Dependability	To ensure the findings of study are repeatable if the inquiry occurred within the same cohort of participants.	<ul style="list-style-type: none"> • Rich description of study methods • Establishing an audit trail 	<ul style="list-style-type: none"> • Prepare detailed description of the study design and protocol • Record the data collection process

Confirmability	To extend the confidence that results would be confirmed or corroborated by other researchers.	<ul style="list-style-type: none"> • Triangulation • Reflexivity 	<ul style="list-style-type: none"> • Apply different triangulation techniques (data source and analytical) • Use reflexive journal
----------------	--	--	--

Lincoln and Guba (1985) describe rigour within qualitative research as achieved when findings are noteworthy and sound credible to the participants. Paterson and Higgs (2005) recommend that the descriptions authentically reflect the experience of the people that lived and shared their stories of the phenomena being researched. They suggest that credibility relies on: the authenticity (the meanings arrived through open-ended questions to gather as much of the description as possible); the plausibility (the fit of research findings with the direct quotes of participants); and the trustworthiness of the analysis (the checks and balances obtained through checking with participants and going back to the data).

Of the four measures or standards of rigour outlined in Table 3, the measure of transferability or how well the findings from one context could fit with a similar second context poses a potential problem. This is because the goal of IE is to explain the relations of ruling from a particular lived experience; its goal is not to generalise. This speaks also to potential participant bias where two people experiencing the same situation offer different perceptions of the event. While it was highly unlikely that I would encounter two such participants, there was no way to control a particular participant's bias, meaning how they perceive an event as based on their location, their experience, their subjectivity. To minimise this, I asked participants about actual occurrences instead of relying on shared misunderstandings.

Basailon (2012) suggests that rigour in an IE study is demonstrated when “the researcher clearly and convincingly shows how things are organised to happen in the material circumstances of people's day-to-day lives; where an explication of the ruling relations that shape or coordinate people's circumstances is produced” (p. 111). Smith (2006) argues that IE analysis is neither qualitative nor quantitative, but instead descriptive in words and numbers of what is actually happening and is evidence-based. As there is no standardised method or format for documenting data analyses in IE studies, I propose that IE researchers can also demonstrate credibility, dependability, and confirmability (as described in Table 3) by detailing how and what data were collected and analysed. Accordingly, in Table 4 I detail how my analysis was conducted as a form of authenticity and transparency.

Table 4. My process of data analysis

A broad overview of tasks accomplished at each phase of data analysis

Phase	Data Type	Details
Organising of data	Transcripts	<p>Transcribe audio recorded interviews.</p> <p>Read and correct transcripts by listening.</p> <p>Create a list of categories for indexing all texts.</p> <p>Import corrected transcripts into NVIVO. Note documents such as policies, manuals, Acts guidelines and policies that were referenced in interviews.</p>
	Boss texts	<p>Link these texts to interview transcripts or other texts that reference them.</p>
	Forms/Documents	<p>Locate and import documents into NVIVO.</p> <p>Link parts of any transcript that relate to texts.</p> <p>Read and examine documents for any links to other texts.</p>
Initial Analysis	All texts, transcripts	<p>Index all data using the following categories:</p> <ul style="list-style-type: none"> AMHP work Case examples Ruling relations Disjunctures or anomalies Quotes for later consideration Sources of knowledge on sectioning processes Recommendations from participants Reflective notes
Collating Information	All transcripts, texts	<p>Map how people, texts, and processes are connected to the problematic.</p> <p>Document sources and resources that inform AMHPs' understanding of the problematic</p>

Check back with interviewees	Transcripts, texts	Invite interviewees to review initial analysis results and make amendments.
Final round of analysis: presentations to participants and feedback	Maps	Make notes and adjustments on data analysis based on feedback and discussion.

NVIVO qualitative analysis software (QSR, 2014) was used for the organisation and facilitation of analyses software. This allowed terms to be queried, transcripts to be linked to actual texts, created memos and called up all references to particular indexed terms. Further details on the dissemination are discussed in Chapter 9 of this thesis.

Chapter 4. Framework for data collection and analysis

This chapter provides a detailed overview of the three components of this study's ethnographic fieldwork namely: sources of data, collection activities and strategies for data analysis. I outline the key research techniques and decisions that helped in achieving the study's objectives and led me to learn about standpoint informants' activities and experiences relating to MHA assessments and sectioning processes under the MHA. This provided the opportunity to uncover unofficial/hidden work carried out by social worker AMHPs as well as details about how their work is organised and ruling relations. I also examine challenges I encountered during fieldwork and how I addressed them.

4.1 Phase one data collection

The data collection for this study occurred in two sequential phases over two local authorities in England. The first phase with informants who were all social worker AMHPs employed by local authority 'A' spanned from April 2021 to October 2021. During this time 18 informants consented to talking with me in one-to-one interviews that were between 60 to 90 minutes in duration. When an informant contacted me by email or telephone to inquire about the study, I was often asked about my motivation for designing a study dealing with the overrepresentation of Black people compulsory detained under the Mental Health Act 1983 (MHA). I generally mentioned professional and personal interests in the topics of mental health, social work and health policy. I responded openly to questions, which helped build trust and rapport with informants. The following passage is from my fieldnotes on 16 April 2021. It is an example of the opening sentences that I said to informants enquiring via email or telephone about the study:

Firstly, thank you for showing an interest in participating in my study. As you know, I am conducting interviews as part of my PhD research to increase my understanding of your role in sectioning processes under the Mental Health Act. As an AMHP, you are in an ideal position to give me valuable first-hand information based on your experience and expertise. The interview takes around 1 hour and is informal. I am simply trying to capture your thoughts and perspectives on the policies, procedures and processes, which guide your work. Your participation will be a valuable addition to this research and findings could lead to a greater understanding of AMHP work and may also provide much needed insight into the phenomena of overrepresentation of Black service-users compulsory detained under the Mental health Act. I value and need your knowledge to successfully carry out this research.

I emailed a letter of introduction (Appendix F), information sheet (Appendix D) and consent form (Appendix E) to interested informants. The letter invited informants to contact me if they wished to take part. Once contacted by potential informants I planned for a convenient time for the interview.

At the beginning of each interview, I thanked each informant for agreeing to participate in my research project. Each participant then confirmed that they had read, signed and returned the consent form and agreed to have the interview audio recorded. I also asked each informant for basic demographic information: their gender; ethnicity; age; length of time as a registered social worker; length of time as an AMHP; and which area of AMHP work they were involved with for example, emergency duty team, assertive outreach team, forensic community mental health team, crisis resolution intensive support service. After asking if they had any comments or questions about the intended interview process, I commenced the recording and interviews.

All interviews were generally framed within IE's dialogical approach of "talking to people" (DeVault & McCoy, 2004, p. 756). The importance of detailed analysis of talk is especially relevant to this study as "talk and interaction are the backbone of social work" (Hall et al., 2014, p. 2). During my first set of interviews with informants, I focussed on generating broad accounts of their work and the problems they encountered related to sectioning processes under the MHA with specific emphasis on their experiences with Black and/or Minority Ethnic service-users. The basis of my interview approach is the assumption that work/life is socially organised and can therefore be researched and empirically explored through interview dialogue. Utilising the approach used by Bisailon (2012) and demonstrated in Table 5, I applied the features in IE research therefore, interviews were carried out with a particular interest and tone, which were established early in interviews. This allowed for dialogue with interviewees to be opened up and oriented in certain ways. Informants gave considered and detailed answers rich in specific examples. Interviews flowed easily and I was able to quickly build rapport with informants, moving from one question to another and back again. This ease of rapport was facilitated through my active listening and probing. However, at times, this ease of rapport between informants and myself made it easy to deviate from the intended dialogue, straying from topics that were potentially of the most analytic interest. It was important that I focused on gathering data, which consisted of descriptions of informants' actions, activities and material practices, given that a key tenet of IE is that data collected should consist of information that is empirically traceable and material. In some interviews informants drifted towards talking about personal feelings, which I quite expected. Given that we were talking about highly sensitive and personal matters such as, mental distress, power, ethnicity, discrimination and inequality which informants and I had varying levels of comfort, not to mention the emotional labour involved in informants implicit or explicit involvement in 'dirty work' (Morriss, 2016). Nevertheless, I anticipated and prepared for the risk of being drawn off course during interviews and the challenges I could face with focussing only on material happenings. This is where the information in Table 5 was employed as a practical resource, as I utilised it as a visual prompt, which reminded me of the focus and analytic intent that I wanted to maintain throughout the interview process.

As part of my note taking, I jotted down key words and phrases in order to seek clarifications and not take my pre-understandings as absolute. Although my pre-understandings were informed by my practice experience and by the literature, I made a conscience effort to make a note of key phrases as they arose during the interviews and would routinely return to the to the informant to clarify its meaning. For example,

during a few interviews, informants mentioned that they “had a cheeky look at a service user’s case notes.” I made a note of the phrases “cheeky look” and “case notes” to prompt me to question further about what actually happened in order to make certain I understood what the informant meant. Instead of theorising about possible meanings, it was important that I elicited clear, first-hand descriptions of their experiences: What was done? Why was it done? Exactly what happened? How did these events unfold? Did it affect them in anyway? Were there any repercussions? Was their work affected in anyway?

Due to the COVID-19 pandemic, all interviews took place virtually via Zoom. This meant that participants were usually in personal settings such as their homes or quiet socially distanced spaces within their offices. These settings were particularly conducive to listening, hearing, learning from and talking about the details of informants’ work. In most cases interviews in these milieus were longer than anticipated. The ‘safe space’ and privacy of domestic surroundings allowed for an informal and comfortable environment. This allowed for detailed descriptions, clarifications and silences in order for informants to ponder, and for me to discuss and scrutinise the policies, procedures and texts that mediate their work.

Table 5. Orienting features in institutional ethnographic research (adapted from Bisailon 2012)

IE analytical concept	IE analytical intent
Research is empirical, material and based on the actualities of people’s daily lives.	Listen to “stories” of what practices and activities informants engage in (Diamond in DeVault & McCoy, 2004, p. 756).
Researcher “thinks organisationally” (Smith, 2006, p. 24) and examines how invisible work is shaped, coordinated and regulated by institutional systems.	Orient interviews toward aspects of social organisation that coordinate informant activities (social relations).
Investigation adopts an explicit standpoint based on the everyday actions of informants. This perspective is maintained throughout an inquiry to scrutinise the work and organisation of institutions.	Uncover what issues, troubles and concerns are of priority to standpoint informants.
Problematic investigated through the researcher’s immersion in the field.	Reveal where institutionally written policies and procedures and actual work practices are at odds with each other with a view of identifying work processes

	implicated in the production or maintenance of the problematic.
Inquiry pays particular attention to established procedures that are mediated through texts and other documentation.	Discover ways in which texts and documents organise what informants say and do in practice (discursive organisation).
Investigation looks for organisational features that operate across and through multiple sites and are integrated into daily work processes, which determine how work is coordinated and carried out.	Identify ruling relations that inform and shape informants' everyday work activities.
Investigation is interested in how the informant's social location informs their knowledge.	Reveal the social organisation and ruling relations of organisations.
Researcher develops increasing understandings from reviewing texts and interviewing informants. Researcher follows up on reoccurring phrases or words.	Learn which texts and documents informants use in their daily activities and how these are "activated." Informants will talk to the researcher about the work practices of others so that the researcher will identify points at which individuals' actions are impacted by ruling relations.

4.2 Phase two data collection – moving locations

The second phase of data collection took place with AMHPs employed by local authority 'B' from November 2021 to April 2022. The tandem research phases were marked by a change of institutional interview site. The rationale behind sequential fieldwork phases and locations is to explore and compare with the latter, concerns and questions that emerged from interviews with the former. Interviews in phase two of my data collection enabled me to fill gaps in my knowledge and understanding based on information I gathered about the features of the work practices and experiences of informants from local authority 'A.' This fits the on-going and unfolding nature of the IE research process (Campbell & Gregor, 2004). Since this IE did not study the informants per se, the new interview questions that evolved pertained to AMHP work processes. Examples of the evolvement of new questions include informants sharing their thoughts on the benefits of having a dedicated commissioned conveyance service provider instead of relying on NHS

ambulance services which prioritise physical acute life-threatening conditions over a person detained under S6 MHA. Informants shared stories of having to wait in excess of four hours for conveyance to arrive. Following these stories, I included subsequent interview questions about the potential impact of utilising a dedicated commissioned conveyance service on MHA assessments and sectioning processes under the MHA.

According to McCoy and DeVault (2004) each interview is “oriented to sequences of interconnected activities that build up an understanding of the coordination of activity in multiple sites” (p. 757). The various case examples of MHA assessments that informants discussed at interviews, along with their knowledge of relevant legislation, the role of other professionals and support services, allowed me to identify the relevant government bodies, professionals and people who play key roles in sectioning processes under the MHA. Defining the assessment process and all the activities it generates as ‘work’ provided a framework for dialogue with research participants.

This summary of my data collecting activities accurately portrays to the reader how I engaged in fieldwork for this project and explains the rationale behind my research decisions. However, this hermetic account somewhat conceals the reality that my actual experience of fieldwork was far less linear and much more organic and messier than I am able to convey. Expressing in words the fluidity of the fieldwork where data collection and analysis was a dynamic, sometimes disorderly experience – is challenging. Although an iterative and engaging process, my data collection and analysis sometimes overlapped as I moved back and forth from the literature to the fieldwork; from transcribing audio recordings to re-reading texts and from reviewing transcripts to coding. This corresponds with how Seidel (1998) as shown in Figure 7 describes the data analysis process as recursive since one activity can call you back to a previous activity. Seidel further describes the process as holographic as each step in the process contains the entire process. Sometimes moving recursively between these activities and my thinking about them jounced each other making way for some interesting and unexpected fieldwork experiences, reflections and conversations with my PhD supervisors. This reiterates the notion that fieldwork is a “lived dilemma rather than simply the neat achievement presented in a written report” (Yates, 1995, p. 23 in Weinberg, 2002, p. 79).

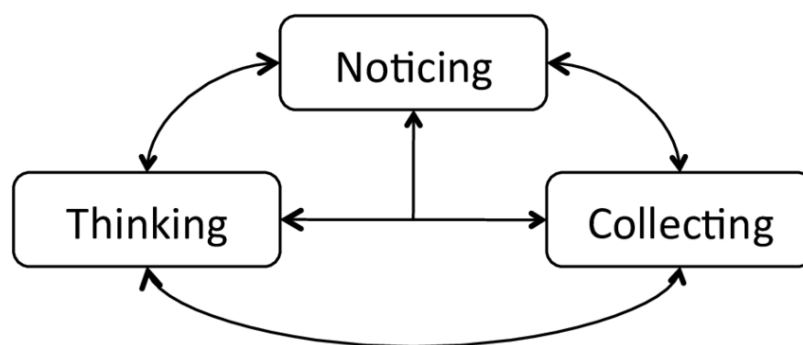


Figure 7. Qualitative data analysis: A Model of the Process (Seidel, 1998)

For example, after I had conducted and transcribed fourteen interviews, I found that there were certain shortcomings in the data and, by extension, my understanding of and appreciation for informant experiences and accounts of sectioning processes under the MHA. In particular, on reviewing the demographic data of informants I noticed that I had only interviewed two informants from a BME background; I felt I needed to have a better understanding of the experiences of informants from BME backgrounds since my research was focussed on the disproportionate detention of Black service-users under the MHA. Coffey and Atkinson (1996, p. 2) recommend:

“...we should never collect data without substantial analysis going on simultaneously. Letting data accumulate without preliminary analysis along the way is a recipe for unhappiness, if not total disaster.”

This approach of doing data analysis while collecting data is called the "principle of interaction between data collection and analysis" (Erlandson et al., 1993, p. 114). What I identified as a shortcoming in the preliminary analysis of my data, led me to consciously initiate opportunities to interview informants from BME groups. I used my contacts with AMHP service managers who acted as gatekeepers, as well as the BME informants I had already interviewed, to organise these additional interviews targeted specifically at BME informants.

4.2.1 Data saturation

According to Faulkner and Trotter (2017), data saturation refers to the point in the research process when no new information is discovered in data analysis, and this redundancy signals to researchers that data collection may cease. In terms of interviewing, reaching saturation implies that a researcher can be reasonably assured that further data collection would yield similar results and serve to confirm emerging themes and conclusions (Faulkner & Trotter 2017).

I interviewed participants until saturation was reached to ensure data adequacy and depth of understanding (Francis et al., 2010). This approach involved continuous analysis of incoming data during the data collection process to determine when saturation has been achieved. The decision to stop data collection at the point of saturation is fundamental in qualitative research as it signifies that data collection has addressed the research questions comprehensively (Faulkner & Trotter 2017).

Achieving data saturation in this study signified the completion of the data collection phase as no new information or themes were emerging, which ensured a thorough exploration of the research topic. This approach supports the credibility and validity of qualitative findings by demonstrating data sufficiency and comprehensive coverage of the study area (Francis et al., 2010).

4.3 Procedure for data analysis

I audio recorded and transcribed informant interviews. I made written fieldnotes during and immediately following each interview. I made notes of my observations and topics to follow up in future interviews. This allowed me to produce rich, thick descriptions typical of ethnographies. When arranging interviews, I ensured that I scheduled a maximum of two interviews per day. This was a pragmatic strategy that facilitated my completion of written notes after interviews and allowed me to manage fatigue and self-care, following particularly lengthy interviews. There was a memorable experience where a potential informant expressed concern and resistance to being voice recorded. The informant, who initially agreed to be interviewed, later rescinded since they had concerns about being identified in the reporting of research findings.

I also benefitted from participation and membership of various 'epistemic communities' (Haas, 1992; Cross, 2013) before, during and after my fieldwork. These were useful sources of data in the form of feedback on my research design, emerging results and preliminary findings. According to Erlandson et al. (1993, p. 140) "peer debriefing," the process of "allowing a peer who is a professional outside the context and who has some general understanding of the study to analyse materials, test working hypotheses and emerging designs, and listen to the researcher's ideas and concerns" helps to establish research credibility. I participated in The British Association of Social Workers (BASW) webinar entitled 'The Mental Health Act, Race and Ethnicity: What are the key issues for AMHPs now?' (October 2020), which explored MHA assessments and considered issues for BME AMHPs and service-users. This event was co-organised by Mark Trewin, the Mental Health Social Work Lead in the Department of Health and Social Care; Ruth Allen, the Chief Executive of BASW and the National AMHP Leads Network. I presented my research design at an International Centre for Mental Health Social Research (ICMHSR) seminar, which brings together researchers from the University of York and other universities to apply social science to mental health policy and practice, this was facilitated via webinar by Professor Martin Webber, Director of the ICMHSR (March 2021). I submitted an abstract and was accepted as a panellist to discuss my fieldwork experiences and observations at the AMHP National Conference (May 2021) facilitated by Dr Caroline Leah and Dr Kevin Stone of the AMHP Research Group, a network that encourages collaboration between practitioners, researchers, public and policy makers. Likewise, presentations I gave at the 'Think Ahead Mental Health in Social Work' conference (March 2021); University of York's Race and Ethnicity Skills Day (October 2021) and bi-annual thesis advisory panel meetings were events through which I discussed my fieldwork and emerging findings from this study. My interactions at these events took the form of presenting, leading discussions, fielding questions and reflecting on critique and feedback from attendees who included academics, professionals, service-users, carers, fellow students and the public. These exchanges of knowledge were invaluable and allowed me to confidently commence my analytic work with the considerable amount of data that I had collected.

In the sections that follow, I explain the work I carried out in the data analysis phase of this project. There were three interconnecting phases involved in the analysis of the data collected for this research. I began by transcribing and reading the data, followed by marking up the data and ended with writing about the data.

Data analysis was an iterative process that began with the first interview and continued throughout the writing of this thesis.

4.3.1 Phase 1: Familiarisation with the data

My analytic thinking began during my interviews with informants, and similar to DeVault and McCoy (2006, p. 23) I viewed interviews as somewhat of an “analytical rehearsal” where I checked my understanding as it developed and offered up to the informant for correction and confirmation. During the interview process, I was acutely aware that as the chief investigator in this project I was not the only person engaging in such analysis. Persons being interviewed also engage in what Holstein and Gubrium (1995, p. 56) refer to as “indigenous coding.” This means that interviewees may also analyse what they say while being interviewed. I took this into consideration when I started to analyse data from interviews.

I listened to audio files and transcribed interviews verbatim. I scrutinised both collected texts and my own fieldnotes intensively in order to familiarise myself with the data. I re-read transcripts and re-listened to interviews at least four or five times with the assumption that successive revision of data would facilitate potential discoveries and rediscoveries (Smith, 2005). The aim of my analysis was to present convincing and rational arguments based on my identification and examination of informants’ work activities including taken for granted practices and unnoticed “work,” considering tensions these presented for informants and identifying clues about the social organisation of these contradictions. The analytical value of these activities is that they provide an insight into the unaccounted for and often subtle features of the relations of ruling within a setting.

In this study, an early finding was that informants engage in activities co-ordinated and supported by multiple agencies in order to correctly proceed through assessment and sectioning processes under the MHA. Informants’ work was never solitary or focused on an individual professional perspective. Rather, it is rooted in philosophies of a collaborative multidisciplinary and multi-agency approach, which involve service providers and professionals outside the field of health and social care, such as the police service and criminal justice system. There is much (much) more that can and should be said about the coordination of informants’ experience from their perspective at the intersection of the organisation of knowledge and practices of medical practitioners, the police and conveyance providers and how informants engage with these agencies in the context of their work and statutory duties under the MHA. It was evident from early in my analysis that informants, notwithstanding their legal requirement to make an independent judgement during the process of assessment, found working with colleagues who may have different perspectives and professional values challenging. These challenges and tensions will be examined as part of my analysis. Of particular interest is how the presence of professionals such as medical doctors (S12 MHA), the police in (MHA sections 135 (1); 135 (2) or 136) and conveyance providers (S137 MHA) generate specific sets of institutional practices and how medical advice and forms of knowledge from other agencies mediate the work practices of informants. How are informants and the professionals they work with informed? What concepts do they

draw on? What impact if any, does this have on the MHA assessment and people subjected to assessment? There is paucity of research with this focus in the social science literature. These connections are the pieces of a bigger puzzle I aim to know more about.

4.3.2 Working with texts during fieldwork

Consistent with IE's particular relationship to and interrogation of texts, I accorded prominence to locating documents relevant to MHA assessments and sectioning processes in the lead up to fieldwork. As previously mentioned, these "boss texts" (Griffith & Smith 2014) are key texts commonly used by AMHPs to gain insights into the foundational principles and legal frameworks guiding their practice.

Throughout and after fieldwork, I continued to search for and review relevant documents, anticipating the discovery of new resources used by participants in their daily practices. However, contrary to expectations, participants did not directly reference these boss texts when describing their work processes and decision-making strategies. Instead, they relied on tacit knowledge of mental health legislation acquired through experience and MHA assessments to justify their decisions. This reliance on professional expertise underscored their implicit understanding of legal requirements and procedural guidelines in AMHP practice.

This finding underscores the significance of participants' practical knowledge and experiential learning in shaping decision-making processes, supplementing formal text-based knowledge (Billett, 2001). Participants' ability to articulate decision-making rationale based on tacit knowledge underscores the nuanced and context-specific nature of AMHP practice (Polanyi, 1983).

While initial familiarity with formal texts was important for establishing background understanding, the study's focus evolved towards capturing the nuanced decision-making processes shaped by practitioners' experiential knowledge and professional judgment. This approach enriched the study by uncovering the complex interplay between formal guidelines and practical expertise in AMHP practice.

4.3.3 Phase 2: Sorting and coding the data

During successive readings, I colour coded textual data such as fieldnotes and transcripts. While reading transcripts and other materials, I separated the data into five categories, namely: talk, texts, work, institutions and people (Appendix J). I used the highlighter tool in Microsoft Word (hereafter referred to as Word) to assign a different colour for each of the categories. Focussing on what I found relevant to the research questions, I noted the following: 1) Talk - What jargon and language informants use in their descriptions; 2) Texts - what documents informants revealed in their talk or brought to the interview; 3) Work – what informants are doing and their interactions with others; 4) People- who informants interacted with directly or indirectly; 5) Institutions – what organisations or agencies were referenced.

Interview transcripts and texts were indexed in a Word file that corresponded with the five categories (not coding for themes but rather references to institutions, texts, forms of work and so forth) (Appendix J). Table 6 shows how I further subdivided and named these based on the topics in the data as they emerged in informants' description of their activities and is coloured with the same codes (Appendix J). Statements by informants about features of social organisation were copied and pasted from transcripts into the files and sub files. This process of coding the data was the pivotal link between collecting data and analysing the data. According to Charmaz (2012, p. 5):

“Codes rely on interaction between researchers and their data. Codes consist of short labels that we construct as we interact with the data. Something kinaesthetic occurs when we are coding; we are mentally and physically active in the process.”

In this sense, this study has employed a grounded theory framework for analysing data. Kelle et al. (1995, p. 42) explains that, “In grounded theory the researcher starts by reading and carefully analysing a small amount of data and then ‘codes’ (read and analyse) the data (most often text) by following very detailed and complex procedures and ‘rules of thumb.’” This is precisely what was done in this study where I listened to and transcribed interviews, read fieldnotes and documents, then coded and analysed them. This method of reading, sorting, marking and coding the data helped me to shape the on-going data collection process. This iterative process enabled the gradual unfolding of cumulative details about ruling relations that inform and mediate informants' everyday work activities.

Kelle et al. (1995) goes on further to explain that during the analysis phase, a researcher employing a grounded theory approach, continually asks questions about the data and checks them by constantly comparing different instances of data. The constant comparative technique is used to find consistencies, differences and anomalies, with the aim of continually refining concepts and relevant theoretical categories (Birks & Mills, 2015; Chamberlain-Salaun, Mills & Usher, 2013). During fieldwork, I used a variety of methods to compare the data. Firstly, I compared them with my pre-existing knowledge on certain issues and read the relevant literature and secondary data for more information. If I needed clarification on a particular issue or to ‘check-back’ my understanding of a work process or technical jargon used during an interview or in texts, I emailed informants directly or spoke to one of the AMHP service managers from the LA in which I was conducting interviews. This always resulted in getting a very good clarification of the issue. Luckily, this did not happen often as I usually sought clarification for things I did not understand straightaway during interviews. Birks and Mills (2015) also suggest that memo writing is an analytic process considered essential in ensuring quality in grounded theory. Kelle et al. (1995) also stressed the importance ‘writing memos’ on the ideas and rationale behind codes and their interrelations as well as drawing diagrams, which visualise the researcher's thinking about the data. I found the writing of memos throughout my fieldwork very useful. This continual comparative iterative process that encompasses grounded theory research, sets it apart from a purely descriptive analysis (Birks & Mills, 2015; Chamberlain-Salaun, Mills & Usher, 2013). This framework of analysis helped me to have a good conceptual structure of the collected data at the end of the

fieldwork period. By the end of my fieldwork and once all the data was collated and coded, I turned my attention to the final stage of my analysis, writing up a report of my findings.

Table 6. Organising the data

Category	Topic	Statements by informants
Talk	Risks and challenges, reflections, resilience, cultural competence, discrimination, ethnicity, class, gender, conflict, resources, training, empathy, unconscious bias	<p>I feel complicit in people’s trauma.</p> <p>It will be useful to learn from people going through the experience of being sectioned.</p> <p>I want to see how my decision develops and has impacted someone’s path.</p> <p>Lack of resources means we don’t have pathways to funnel people into correct therapeutic interventions.</p> <p>Our field of understanding is within the boundaries of what we think is possible or normal.</p> <p>There is a fear of Black people especially Black men.</p> <p>There is a prevailing feeling of dangerousness of Black men.</p>
“Boss Texts” and Documents	MHA Manual, MHA Code of Practice, MHA reference guide, case file, MHA referral, MHA legislation, CTO	<p>The MHA is being reviewed and revised but still driven by majority male society.</p> <p>Risk flags are copied from one report to another and the context of the risk is not looked at.</p>
Work	MHA assessments, CTO, social perspectives, medical model, least restrictive option, decision-making, case load, social work, waiting, assessing and managing risk, recording case notes, working with other professionals	<p>Our autonomy has been taken away with gatekeeping of crisis beds.</p> <p>There is no follow up, how do we learn from our decision?</p> <p>There should be risk engagement instead of risk management.</p>
People	Service-user, doctor, police, family members and carers, case worker, ambulance service, conveyance service, health and social care professionals	<p>AMHP has the most power but least power in hierarchy.</p> <p>Doctors are about compliance and conforming, whereas social work is about who is this person?</p> <p>I think some of the health colleagues don’t understand that it’s a legal responsibility and just what AMHP work involves.</p>

		<p>There's still this issue about other people understanding what we do.</p> <p>I don't think they know about like the case notes, about what I've got to do and how much responsibility I've got when I'm doing an MHA assessment</p>
Institutions	<p>The Police service, National Health Service, Conveyance providers, Local Authority, High Court, Community Care Teams</p>	<p>We shouldn't need to use police as mental distress is not a crime.</p> <p>Police are reluctant to step in if there is no warrant, they don't see it as their role.</p> <p>Each institution is working to different policies and different baselines; risk thresholds are different which makes things like street triage difficult for ambulance crew.</p> <p>Police need more support and training in mental health.</p> <p>I feel like the ambulance is a glorified taxi service.</p> <p>Service-users known to police have more force used.</p>

As suggested by Kelle et al. (1995), I produced analytical diagrams alongside organising, marking up and coding texts and transcripts. As part of my analysis, I found it useful to ask some explicit questions of texts. Keeping in mind how these are referenced or implicitly appear in the texts, for example: statutory authority, policies, procedures, norms, standards, autonomy, gender, race, ethnicity, power, control, people, class, compulsion, ruling relations and the work of other institutions and systems (Appendix K).

Figure 8 is an example of an exercise where I excogitated a way to illustrate how institutions, people, work and texts are connected to informants' everyday work activities. In creating these diagrams, I reflexively analysed and explored ruling relations and local and extra-local institutions involved in AMHP work (see also Appendix L).

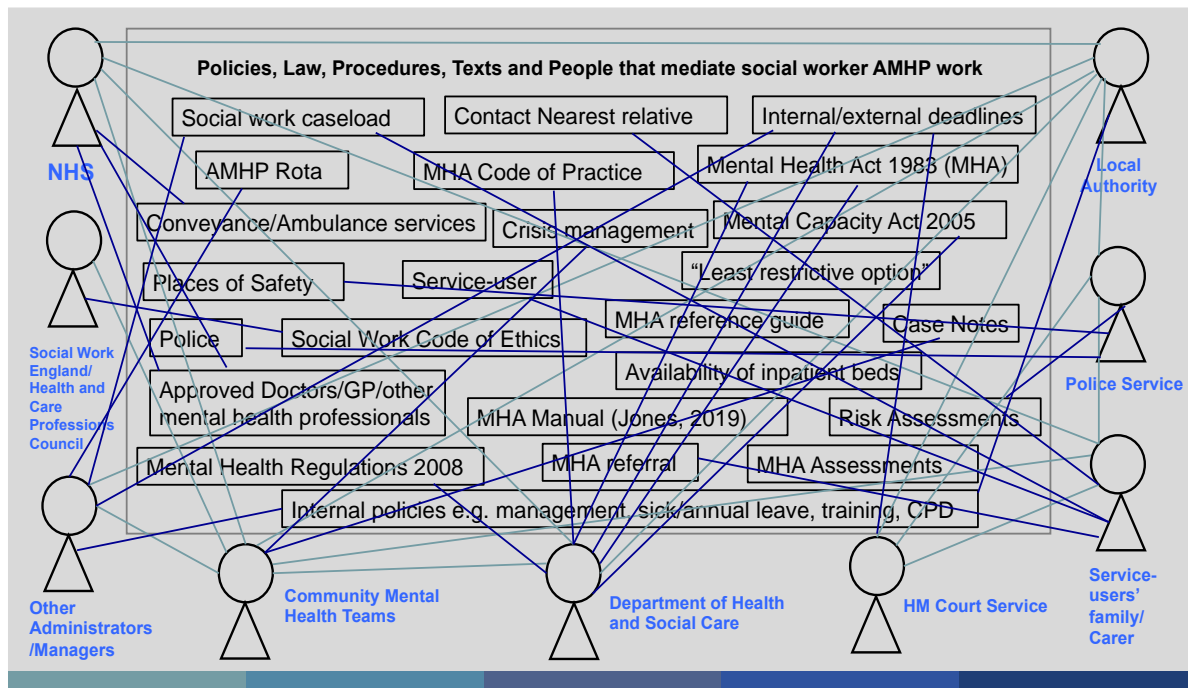


Figure 8. Analytical mapping illustrating how institutions, people, work and texts are connected to informants' everyday work activities

4.4 Presenting the data

I present and discuss the research findings according to the emergent analytical themes in the chapters that follow. Unless otherwise stated, where data originates from interviews, verbatim quotations are used to present the research findings. I report speech indirectly or paraphrase where I am confident that I have understood the meaning and sense but not the exact words the participant has used. In some instances, I have removed sections of interview data due to lack of relevance or space, this omission is indicated using [...].

4.5 Breakdown of chapters

The following four chapters consider the findings from the analysis of the different phases of AMHP work. I map the four main stages participants described in progressing an MHA assessment from the initial referral to post assessment requirements. I then move on to discuss my findings as a whole in relation to my research questions, drawing on my review of literature where relevant in the discussion chapter.

Four chapters entitled: “Risky Business,” “Lost in translation,” “Is it a crime?” and “A cheeky look” are analogies created in reference to colloquial expressions that arose during my interviews with participants. Findings focus primarily on participants involvement with service-users detained under S2 and S3 MHA. Findings also have a more explicit link with participants’ experiences with Black and/or Minority Ethnic service-users.

In Table 7, the essence of the themes is captured, as well as an overview of the data gathered from the interviews by providing a brief definition within the sub-themes. These sub-themes identify key factors participants implicate in the maintenance of ethnic disparities in the outcomes of MHA assessments. For ease of presentation themes and sub-themes are presented in a linear format on paper, however, some of the key points arising from the sub-themes are iterative in practice hence there is some overlap between subthemes.

Table 7. Themes and sub-themes of research findings

Chapter title	Main Theme	Sub-themes
“Risky Business”	Receiving the MHA assessment referral	<ul style="list-style-type: none"> • Contextualising assessing and managing historic and current risks
“Lost in translation”	The MHA assessment interview	<ul style="list-style-type: none"> • Emotional labour: The burden of addressing race and past trauma with Black service- users • Cultural Misunderstandings • Negative stereotypes of Black people • Ethnic inequality within the workforce: Underrepresentation of Black and Minority Ethnic AMHPs and mental health professionals
“Is it a crime?”	The decision and outcome of the MHA assessment	<ul style="list-style-type: none"> • Lack of understanding of role of AMHP by other professionals • Tensions with multidisciplinary working • Disproportionate Police involvement • Poor socio-economic circumstance of service-users • Limited resources/ lack of alternatives to detention
“A cheeky look”	The post-assessment requirements	<ul style="list-style-type: none"> • Lack of feedback from service-users • Taking a “Cheeky look” at case notes after MHA assessment • Lack of opportunities for formal follow-up after MHA assessment

Chapter 5. “Risky Business”

5.1 Introduction

This chapter begins by investigating the informal ways through which participants articulate risk in their roles as AMHPs. It delves into the crucial relationship between risk assessment and decision-making—a key factor influencing the acceptance, progression, and outcomes of MHA referrals. Through a detailed analysis, the aim is to address the research question: *To what extent are the accounts of social worker AMHPs “actual” experiences of coordinating MHA assessments with Black service-users representative of the “ideological” work of AMHPs (are some things unaccounted for?)*.

To achieve this objective, the focus is on participants' descriptions of how actual AMHP work is translated into practice "on the ground." Specifically, attention is given to the processes of risk assessment and the influence of institutional and resource constraints on decision-making. By exploring the interplay between risk assessment and decision-making, the study scrutinises the "extra-legal and non-clinical" (Quirk et al., 2003) factors that shape AMHPs' decision-making processes. These factors include ruling relations emerging from participants' interactions with fellow professionals, agencies, and institutions.

The analysis of these themes aims to provide a comprehensive understanding of the ideological dimensions embedded within AMHP practice and shed light on the complexities of decision-making processes within this context, as informed by both practical experiences and broader institutional dynamics. These findings will be linked to existing literature, contributing to a deeper appreciation of the nuanced challenges faced by AMHPs in their roles.

5.2 Receiving the MHA assessment referral

This theme is concerned with a key stage in the MHA process - referral for an MHA assessment. These requests need to be carefully considered therefore, participants described the process of the early stages of receiving the referral, which is usually received from another professional. Participants provided descriptions and examples of what happens when they receive a referral for an MHA assessment.

5.3 Sub-theme: Contextualising, assessing and managing risks

All participants commenced talking about their work by relating experiences and case stories about the MHA assessment referral. These discussions were mostly centered on participants' accounts of challenges and problems and how people who would have had contact with the person before the AMHP became involved, such as professionals, carers and relatives interpreted these problems. Managing risks was a common thread throughout discussions hence, within this theme, risks were weaved into the perspective of AMHP participants at the point of receipt of an MHA assessment referral. Institutional factors were an

influential component in managing risks in terms of how participants described using the law alongside case notes and other information to consider whether according to S13 (1) MHA there was “reason to think an application ... may need to be made.” The “reason to think” threshold as a matter of law, does not require certainty that an application is needed, only a belief that one *may* be needed. Therefore, if an AMHP is satisfied such an application for admission to hospital ought to be made in respect of the person referred, having considered any other relevant information, then the AMHP has a statutory duty to make an application.

Participants explained that referrals for MHA assessments arose from different people such as health professionals, social workers, nearest relative, other relatives or police officers. Most often those referred for assessment were located in their own homes, places of safety, psychiatric hospitals, residential care or nursing homes. Where there is reasonable cause to believe that a person in a public place is mentally disordered and is apparently a danger to themselves or to other people, S136 MHA allows police officers to take the person to (or keep them at) a "place of safety" so that a mental health assessment can be done. S135 MHA allows police officers to remove (or keep) a person who is not in a public place to a place of safety after the issue of a warrant from the magistrate's court so that a mental health assessment can be done. A place of safety can be a hospital, care home, police station, your or someone else's home or room and other suitable premises. A police station can only be used as a place of safety if a person's behaviour poses an imminent risk of serious injury or death to themselves or another person. A person can be detained in a place of safety for up to 24 hours, however, this can sometimes be extended for another 12 hours.

On accepting a referral, an AMHP is required to be cognisant of and interpret the nuances and concerns that arise as a consequence of the person being referred, the type of referrer and location, as each referral situation brings its own unique complexities and challenges. All participants recounted that included in the referral was information about something deemed serious that occurred in the recent past which substantiated reasons for the current concern about the person. The person subjected to an assessment was described by AMHPs in this regard, for example a participant received a referral regarding a Black man previously diagnosed with schizophrenia who held a knife to his wrist and threatened to cut himself. This incident that occurred in the recent past was used as a bearing on the future where the likelihood of him doing the same thing again was an important consideration. Another example was a participant who recounted an MHA referral pertaining to a Black woman in her early 20's who, in the recent past, after taking a concoction of over-the-counter medications, tied a bed sheet around her neck attempting to hang herself. Again, this event in the recent past was used to consider the potential risk of harm occurring in the future, where preventing her from hanging herself again was the main issue of concern.

5.3.1. Risk to self and/or others

All participants agreed that the concept of risk is a fundamental feature of the MHA, which is critical to their compulsory powers and an integral part in the legal process of compulsory admission (“sectioning”) to a psychiatric hospital. The reason given was that in order for a mentally disordered person to be legitimately detained in hospital under the MHA, is where the person is detained for the sake of their health or safety and/or to protect the safety of others. S2 and S3 MHA illustrate this and provide the legal bases for persons to be detained and admitted for assessment and treatment respectively. An overview in advance may be of assistance in understanding the more detailed discussion that follows.

For admission under either S2 or S3, the nearest relative of the individual or an AMHP must make an application. Certificates from two medical practitioners - one a specialist in mental disorders (generally a consultant psychiatrist), the other ideally the patient’s general practitioner must accompany the application.

Admission under S2 provides that a person may be detained and admitted to a hospital for the purposes of assessment or assessment followed by treatment. Persons can be detained for a period not exceeding 28 days, which cannot be renewed at the end of the 28-day period. S2 MHA provides that two registered medical practitioners certify in writing that the patient:

- (a) is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment for at least a limited period; and
- (b) ought to be so detained in the interests of his health or safety or with a view to the protection of other persons.

Thus, the satisfaction by medical practitioners that a person’s mental disorder is of such nature or degree that they pose a risk to themselves or others. A similar approach appears under S3 MHA, albeit with slightly different wording. Admission to hospital under S3 is for the purpose of treatment and the duration is up to six months. The six-month timeframe may be renewed for a further six months in the first instance and annually thereafter (see S20 (2) MHA). S3 MHA provides that two registered medical practitioners certify in writing that:

- (a) the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital, and
- (b) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section, and
- (c) appropriate medical treatment is available for the patient

A fundamental difference between S2 and S3 MHA is that under S3 MHA the medical practitioners must be satisfied that the risk profile of the patient deems it *necessary* to detain them in hospital in order to administer medical treatment. This difference between S2 and S3 implies that the condition-precedent and threshold for action is greater under S3. This is expected given that S3 is the pathway under which a patient can be compulsory detained and medical treatment can be administered to the patient without their consent. Bartlett and Sandland (2014) speculate that the use of the term *necessary* in S3 MHA contrasts with *ought* in S2 MHA, suggesting that the former entails a slightly higher threshold. Figure 9 is an overview of the of pathway into inpatient care for a person presenting in mental health crisis.

Risk assessment of the person being referred is an integral part of the decision-making process. Participants described the MHA referral in terms of an account of problems which are linked to a person's mental health and framed around the urgent need that "something has to be done" to address the risk this person poses to himself or others. The interpretation of the "something has to be done" is constructed by the referrer who is usually certain that without admission the person's mental health will worsen. It is up to the AMHP to assess the risks and formulate shared understandings with referrers, usually a nearest relative or medical professionals whilst balancing the legal requirement to exercise their independent professional judgment.

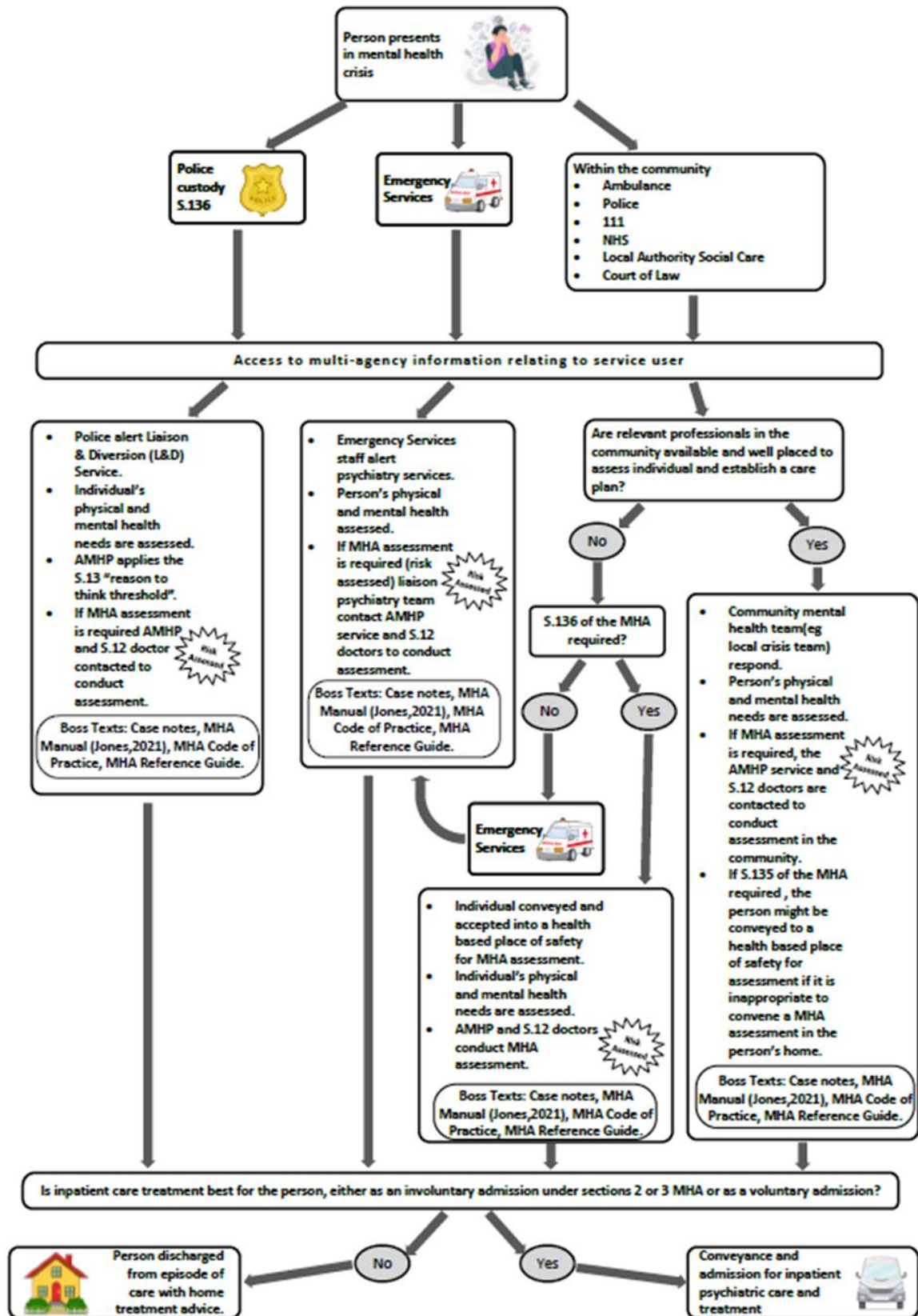


Figure 9. Overview of pathway into inpatient care for a person presenting in mental health crisis

5.3.2 Mandate for social control

There is a higher prevalence of psychotic disorders in people from Black ethnic groups, in particular African-Caribbean people who are eight times more likely to suffer from a psychotic disorder when compared with people from White ethnic groups (NHS Digital, 2022). Higher rates of compulsory detention for Black groups are often attributed to higher rates of diagnosis of schizophrenia within BME populations (gov.uk, 2021a; Barnett, 2019). When asked about their role in risk assessing persons referred for an MHA assessment some participants were sceptical and critical of the “medicalised” approach to risk assessment, which uses the diagnosis of a mental disorder as a basis for making an application under the MHA.

“When I think about it, the Mental Health Act sees a person with a mental disorder who is considered a risk to himself or others in a negative light. Decisions are often based around a medical diagnosis, usually schizophrenia. Sometimes it feels like there is no capacity for positive risk-taking because the main purpose of psychiatric compulsion is social control.” (AMHP 14)

“Even if I (the AMHP) don’t want to make an application and decide risks can be managed, there is this underlying unspoken tension from doctors that if something happens it will be my fault. I feel like I put my neck on the line if I choose to not make an application. I see that mentality more often when the application is for asylum seekers or Black people. Some doctors have the mentality that there are all these hidden risks and dangers that I am not taking account of.” (AMHP 7)

Positive risk-taking is a legitimate therapeutic strategy by which practitioners accept that it is impossible to avoid risks in every case. Instead, service-users’ risks are managed without resorting to compulsion. This approach requires decision-makers to take risks with some service-users who might ordinarily be detained under the MHA (Stickley & Felton, 2006; Higgins, Doyle et al., 2016).

Some participants described coercive action, in particular, making an application under the MHA as a form of social control. Conversely, crisis intervention and avoiding involuntary hospitalisation of service-users through positive risk-taking were seen as therapeutic work. These findings echo the findings of Emerson and Pollner (1976), in which a community mental health team described work with service-users involving coercive action in particular, ordering compulsory hospitalisation was described as “dirty work” or “shit work” and viewed as serving nothing but social control purposes. This finding by Emerson and Pollner (1976) from a study conducted 47 years ago is relevant to this research as it provides significant historical context to the emotional conflict some AMHPs experience in exercising their mandate for social control - a finding which resonates with AMHPs today.

5.3.3 What about risk from others?

The MHA makes provisions under S2 and S3 for AMHPs to assess whether a patient is “a risk to himself and/or others.” There is no provision under the MHA to assess the risk posed by others to the patient.

5.3.3.1 Policing and places of safety

One in four people experience a mental health problem in any given year and many will come into contact with the police either as victims of crime, witnesses, offenders or when detained under S136 MHA (Mind, 2013b). People with mental health problems are more likely to be victims of crime than others and up to 90 percent of prisoners and two-fifths of those on community sentences have mental health problems (Mind, 2013b). Mental health is becoming an increasingly important part of frontline policing in the community. In 2020, West Midlands Police (WMP) piloted and rolled out a system for recording information associated with place of safety monitoring as well as incidents involving S135 and S136 MHA. It is estimated that between 20 percent and 40 percent of police time is spent dealing with mental health related calls and incidents (WMP, 2020).

The police have specific powers under S136 MHA to intervene in a case where a person appears to be in an immediate need of an MHA assessment. Participants explained that police officers often have a significant role to play in MHA referrals and are often the first point of contact for a person in a mental health crisis. Participants recalled instances where persons in mental distress were detained in police custody under S136 MHA and placed in police cells as a place of safety. Participants described the majority of these incidents as involving persons from Black ethnic backgrounds who described feeling distressed and vulnerable after their encounter with the police. Below is a participant’s detailed recollection of one such incident.

“Although the police are involved in ‘one three sixes’ (detentions under S136 MHA) they are not trained mental health experts and often don’t know how to deal with someone in mental distress. There was an Afro-Caribbean man in his 20’s who was picked up looking dishevelled and wandering the streets. He was previously known to the police, who described him as a cannabis user. He was detained under section 136 and held in police cells as a place of safety. He was in a really bad way when I arrived and officers complained that he was shouting and swearing at them. I asked that I be allowed into the cell to speak to him. The police said that he was violent and that I was putting myself at risk. When questioned on what sort of violence occurred, police described verbal abuse. I entered the cell to speak to the man face to face. He immediately calmed down and explained that he had been forcibly restrained by three officers, handcuffed, strip-searched, and placed in a cold cell on his own. He said he had been verbally abused and patronised by police officers and that he was very angry. He explained that he had stopped taking his medication, which caused his mental health to deteriorate. This man was articulate and able to explain what was happening to him. He just needed to be respected and listened to. I think experiences like this

increase Black people's distrust for police and mental health services and also make vulnerable people feel criminalised and discriminated against.” (AMHP 22)

5.3.3.2 Iatrogenic risks

In the quotes below participants describe concerns about iatrogenic risks that could result from persons receiving compulsory medical intervention.

“I don't think we really understand what goes on in the human mind. I have real issues with the term schizophrenia and labelling someone, especially a Black man as schizophrenic.... I've had referrals and gone on to assess young Black men labelled schizophrenic. When someone is diagnosed with schizophrenia what does that really mean? It's just an umbrella term used to describe a collection of symptoms. Then the person is labelled schizophrenic and a risk to themselves and others. You think well, what does it mean for the individual? It's not personalised, is it? The most worrying consequence of being labelled schizophrenic is every few weeks you get jabbed in the bottom with medications that make you feel like shit or could even kill you. If the person or family question it, they are accused of being difficult or worst yet making accusations that it is racist.” (AMHP 25)

“There is always an element of fear in service-users and their families about the impact of psychotropic medication. I had an Afro-Caribbean mother describe her son's medication for schizophrenia as 'White man's poison.' I've also been called 'slave catcher' by a Black man. It's upsetting but I could understand why some communities have such fear and distrust for mental health services. They see us as risky just as we view them in terms of risk.” (AMHP 6)

Findings indicated that MHA referrals submitted by police and medical practitioners tend to focus heavily on the “risk to self and others” element of the MHA referral, with the risk of violence, suicide, self-harm and substance misuse being most frequently reasons for risk concerns. Conversely, iatrogenic risks and risks from others are not readily considered during risk-based decision-making. Overall, there was limited evidence from participants of the inclusion of positive risk-taking opportunities during the risk-assessment stages of an MHA referral and “risk-management” as opposed to “risk-engagement” was the default approach taken when considering whether to accept an MHA referral. Assessing and managing risk appears to be the fulcrum on which compulsion under the MHA relies. Findings indicate that considerations about the level and severity of risks are determined by decision-makers thus rendering risk assessment highly discretionary. Unless otherwise indicated, the term “decision-makers” will be used throughout this thesis to refer to AMHPs and medical professionals who are authorised to apply for or recommend the use of the compulsory powers under the MHA. The term “decision-maker” should be interpreted accordingly.

5.3.4 The temporality of risk

Participants' assessment of risk was closely linked to the phenomenon of temporality where actions of the past are used to predict future potential for risk and harm. Temporality is used alongside the MHA to assess the degree of risk. Yet, despite its significance the MHA neither defines the concept of risk nor delimits its scope. When asked how they assessed risk, participants shared their experience on the complexities and challenges associated with assessing and contextualising risk, with particular attention on their experiences when the person being referred is from a BME group.

“When you get the referral there is certain information you look at first: Are they known to services? Is it male or female? Is it hospital or community? Is it Black or White? Is it young or old? Where do they live, rural or urban? We read the case notes but you’re also doing your own risk assessment in your head, you’re trying to build a picture.” (AMHP 15)

“There is too much emphasis on ‘risk to others’, which I think is a very subjective thing. From my experience historical risks tend to follow Black men, I’ve had to question why something that happened over 10 years ago is still flagged as a risk. When do you stop being accountable for something that happened when you were 20 and now you are in your 30s or 40s? When does it stop? How far back in the past are we allowed to go? I find this happens mostly in cases involving Black men.” (AMHP 7)

Participants also describe the referral as challenging to orient and unpick, linked to this problem is the situation where there is an absence of previous history when the person being referred is unknown to or had no previous contact with mental health services. The implication of this is that there is no recorded history or case notes that could be used by the AMHP as a source of additional information to assess risk. Referring to this difficulty, informants explained:

“When the referral came through it was really difficult to unpick, you know, figuring out what were the main issues because this was his first episode psychosis and he had no previous contact with mental health services, no previous history with mental health services, no written record, nothing to reference.” (AMHP 22)

“Referrals are often framed around asking what is wrong with this person? As opposed to, what has happened to this person? This makes it quite difficult for us to figure out from the referral and case notes whether the person is currently a risk to themselves or others, especially if we don’t have any other information to go by, no previous history.” (AMHP 19)

Participants describe case-notes as a structured electronic record that contains detailed service-user information and events pertaining to a case. These events include meetings, visits, risk assessments, phone calls with service-users, other professionals and agencies. However, participants indicated that when

interactions were unplanned that is, occurring outside the predetermined work process such as an assessment or visit, they had discretion to determine what should and should not be noted on the electronic case file as well as prioritise the urgency in which case notes were entered on the electronic case file.

A finding is that the existence of a previous documented history with mental health services or case records with previous risk assessments play an important role in AMHPs' attempt to contextualise and orient an MHA referral. Whilst the purpose of recording accurate and timely case-notes was procedurally embedded as part of the system that included AMHP work and the electronic template structured accordingly, there was also an unstructured part in which AMHPs could update the case file with whatever information the author judged to be important or necessary.

There was evidence of possible "hindsight bias" (Stone, Vicary & Spencer-Lane, 2020, p. 197) where participants spoke about their reliance on previous risk assessments to determine current risks, often overlooking context and temporality when assessing risk. The following quotes show some examples of hindsight bias in risk-assessment of the MHA referral. This approach to risk assessments is based on unreliable, irrelevant information that favours quick decision-making where service-users' histories are used to determine instead of inform how AMHPs assess risk.

"Risk flags are copied and pasted from one report to another and most times the context of the risk is not looked at. If you don't challenge it some people have a risk history that just follows them around." (AMHP 9)

"When I receive a referral, I often rely on previous case-notes in order to help assess and mitigate risks. I find that if the file indicates someone was previously admitted to a PICU (psychiatric intensive care unit) ward as opposed to an acute ward then the automatic assumption is that they are a greater risk to themselves or others I'm tempted to make that automatic assumption without taking account of the current risks. I've seen it happen to a Black man where having a PICU on the file increased the perception of risk, doctors are the most risk averse in those situations." (AMHP 18)

"The clock starts ticking the minute you receive the referral and it's usually a fast-paced unfolding scenario where someone is in crisis. Time and workload pressures mean that previous risk assessments play a crucial role in framing current risks. If previous decisions not to make the application led to an adverse event, then you're most likely to consider making an application this time around in light of a previous experience." (AMHP 28)

5.3.5 Tensions related to justifications for referral

Participants gave examples of the tensions that sometimes accompany the referral for an MHA assessment. Medical professionals and relatives were often key players in terms of their proximity to the person referred and their experience of the behaviour causing concern. Health professionals had often had contact with the person before the AMHP became involved and were likely to be the instigators of the MHA assessment referral. A relative might be unduly influenced by the views of an assertive doctor who is certain that without admission their relative will experience a further relapse in their mental health condition, this situation could also occur conversely where an assertive nearest relative can influence the recommendations of a medical practitioner. This is referred to as the “anchoring effect” (Stone, Vicary & Spencer-Lane, 2020, p. 196) where someone relies heavily on one piece of anchoring information to inform his or her decision. The referring professional or nearest relative at the time of application has already formed a view that risks are such that assessment and or treatment in hospital is necessary. In this sense, the referral is in most cases instrumental to a desired outcome.

An informant provides the following example of the tensions faced regarding justifications on whether an application should be made in respect of an MHA referral submitted by a doctor.

“I received a referral from a doctor with respect to a Black man who had a diagnosed personality disorder and was threatening to jump off from the top of a block of flats. This was the second referral in six months and the scenario was substantially the same. The man had previously threatened suicide when his relationship with his partner broke down. His family were very concerned and felt he should be admitted to hospital. After gathering and assessing the referral information I formed my opinion about the situation and decided not to accept the referral. I then had an irate doctor on the phone to me... and he said to me, ‘On your head be it if anything happens to this man! I thought if an AMHP had 2 medical recommendations you must make an application.’ Doctors and family have this mindset that we (the AMHP) should rubber-stamp everything. I had to remind the doctor that it’s the AMHP, we make the decision, this is the independent decision we make... We make the application not yourselves, but that mentality of the doctor knows best is something I always struggle with.” (AMHP 16)

5.4 Summary

In this chapter, I have illustrated that central to the acceptance and progression of an MHA referral is the interpretation and assessment of risk. This brings an additional complexity to the everyday doings of AMHPs. Furthermore, participants frequently relied on textual accounts of historical risks through case-notes, which are sometimes used to circumvent time-consuming processes of information gathering. Whilst participants are mindful that they are required to exercise their independent professional judgment, case files played a fundamental role in the textually mediated process through which they gathered and assessed

information. However, case files did not always contain accurate relevant information on which risk-based decisions could be made.

The MHA provides no real function in monitoring decision-makers' understandings and interpretations of the notion of risk which is intrinsic to AMHP decision-making. Hence alongside the MHA, practitioners use the language of risk to justify the need to progress MHA referrals. The notion of risk has emerged as a contested, "complex [and] socially constructed" (Szmukler & Rose, 2013, p. 137) concept. This raises key questions around AMHPs' ability to apply this complex concept with any certainty in more specific contexts where conscious and unconscious bias may impact decision-making.

In the next chapter we discuss findings in the next stage of the MHA referral process – The MHA assessment.

Chapter 6. “Lost In translation”

This chapter moves on from the participants’ accounts of receiving and accepting an MHA assessment referral to the second stage in progressing an MHA assessment - the MHA assessment interview. The second research question: “*When applying the least restrictive option and bringing the social perspective to bear on their decision, what factors influence AMHPs’ consideration of whether to detain an individual under the MHA? Are there specific implications for Black service-users?*” is addressed. My analysis leads me to consider the complex interactions between AMHPs, individuals subject to assessment, nearest relatives and professionals. In doing so, it also discusses the impact of language and culture in MHA assessments but also moves beyond it to consider the *ruling relations*, which maintain ethnic disparities. Participants have highlighted some practice issues that impacted how feasible it was to adequately address disparities in mental health experiences and outcomes for Black service-users.

The phrase “Lost in translation” encapsulates the theme of this chapter and is a generous conceptualisation of the difficulties experienced by participants when communicating with individuals undergoing MHA assessments. This metaphorical expression suggests a multifaceted breakdown in communication that extends beyond mere linguistic barriers. Participants frequently described encountering challenges in conveying and comprehending nuanced meanings, intentions, and emotions during interactions with individuals undergoing MHA assessments. This extends beyond literal translation issues to encompass broader complexities in understanding and interpretation. The term reflects a broader context where misinterpretations, misunderstandings, and miscommunications occur due to differences in perspectives, cultural backgrounds, and contextual factors. It underscores the intricate nature of communication dynamics within the AMHP role, highlighting the significant impact of these challenges on decision-making processes and outcomes.

Participants’ narratives illustrate instances where attempts to convey complex legal and procedural information were met with confusion or resistance, resulting in potential misrepresentations or incomplete understandings. The concept of being “Lost in translation” therefore serves as a poignant metaphor for the multifaceted communication hurdles encountered by AMHPs, encompassing linguistic, cultural, and contextual dimensions that influence the assessment process under the MHA.

6.1 Understanding the individual being assessed

As part of the process of gathering information on the individual subject to a MHA assessment, the AMHP relies on and interprets a range of background information provided by a number of sources. This may include relatives and professionals as well as the AMHP’s own face-to-face interaction with the person being assessed. For non-English speaking service-users, this is sometimes facilitated by an interpreter. This approach to information gathering is non-linear and often times the different sources of information are

informing and informed by the other. In describing their role in the MHA assessment process participants sought to understand the individual being assessed through the information gathered pre-assessment from investigative work undertaken whilst gathering evidence to justify the progression of an assessment. Whilst facilitating the process of information gathering and understanding the individual, participants rely on information provided by relatives, professionals and interpreters. Within the context of an MHA assessment where individuals being assessed are often times in acute mental distress, information provided by professionals and relatives usually bears more weight when compared to the views of the individual being assessed. While this was not the case for all MHA assessments, as will be discussed in this chapter, information gathered by the AMHP from interpreters, professionals, nearest relatives and others sometimes form an imbalanced coalition, which usually underpins the AMHP's understanding of the individual subject to an MHA assessment. According to Stone and Spencer- Lane, (2020, p. 67) "an AMHP needs to be tuned into connotations and nuances arising as a consequence of the type of referrer or location."

6.2 "Push-back"- Challenging other people's perception of the person being assessed

AMHPs interviewed did not always accept relatives and/or professionals' views about the individual being assessed under the MHA. Situations where it is likely that the perspectives of relatives might be given less priority could be when MHA referrals are rejected and not accepted by AMHPs or when MHA assessments do not result in detention. One participant gave an account of challenging a family member's perception about her brother who was being assessed under the MHA in what AMHP 16 described as a "push back."

"Sometimes you could sense other tensions within the family dynamic.... I conducted a Mental Health Act assessment in the community. The case involved an Afro Caribbean brother and sister who were cohabitating, there was an ongoing dispute between them concerning ownership of the property they lived in. The sister, who was the nearest relative, referred her brother for a Mental Health Act assessment. Serious self-neglect was used as evidence of his deteriorating mental state with his sister describing him as dirty and unkempt with his bedroom in a cluttered mess. I had to push back and question her perception of him because when I visited the home, that wasn't the case, although her brother was struggling with his mental health he and his room were both reasonably tidy...actually, he reminded me of my brother, they spoke and carried themselves in a similar way." (AMHP 16)

In the example above AMHP 16 refuted a relative's claims of "serious self-neglect" and the assumption of deteriorating mental health requiring compulsory detention to hospital. What was unique about this case is that AMHP 16 revealed that they shared the same "cultural identity" as the service-user and his family.

Jane Collier and Milt Thomas (1988) combined the ethnography of communication and social construction in order to frame the properties of cultural identity also known as cultural identity theory (CIT). According to Collier and Thomas (1988) cultural identity is self-identification, a sense of belonging to a group that reaffirms itself. It is the extent to which one is a representative of a given culture communicatively, behaviourally, sociologically and psychologically. It consists of values, meanings, customs and beliefs used to relate to the world. It reflects the common historical experiences. This includes the use of core symbols (expressions of a group's cultural beliefs and theories about the world around them), names, labels and shared cultural codes, norms (expected standard of behaviour) that a cultural community share and follow in order to show that they belong to a particular group and demonstrates shared identity. Collier (2009) found out that there were some similarities in cultural norms for members of each ethnic group and there are within group differences with regard to gender and nature of relationship. CIT has been widely applied to examine the role of cultural identities across contexts ranging from interracial marriages in the United States to intercommunity groups in Northern Ireland (Thompson & Collier, 2006; Collier, 2009).

The concept of cultural identity and CIT is of interest to this study, especially when considering the role of cultural identity in the AMHP/service-user relationship. In particular, the impact of intercultural communication (communication between two or more distinct cultures) and intracultural communication (communication between members of the same dominant culture) (Sexton-Roy et al., 2017) on the outcome of MHA assessments. Further, cultural identities are evident at both micro-level interactions between AMHPs and service-users as well as macro-level communications across institutions. Therefore, the manner in which AMHPs experience and communicate their cultural identities may differ across communities and contexts.

AMHP 16 did not initially detain the person in the example given. Part of the reason given was because the views of the person being assessed were taken into account and the relative's perception of serious self-neglect was not supported by evidence. AMHP 16's perception of the person being assessed contradicted that of the relative's as AMHP 16 found the person and their personal space to be reasonably tidy. This view could have been influenced by the fact that AMHP16 shared the same cultural identity as the service-user and therefore had a more nuanced understanding of norms and expected standards of behavior. Additionally, AMHP 16 empathised with the service-user who behaved and reminded them of their own brother and family dynamic. AMHP 16 also considered an ongoing family dispute not related to the service-user's mental health, which was mentioned during the MHA assessment. The brother suggested that the ongoing dispute might have influenced his sister's decision to refer him for an MHA assessment.

Cultural identity theory (Collier & Thomas, 1988), is relevant to understanding the dynamics at play when AMHP 16 refuted claims of "serious self-neglect" and challenged assumptions of deteriorating mental health that would necessitate compulsory detention. In this unique case, the AMHP disclosed sharing the same "cultural identity" as the service-user and their family – "He reminded me of my brother...".

This scenario aligns with cultural identity theory (Collier & Thomas, 1988), which posits that individuals' self-concept and behaviour are influenced by their cultural group membership. In this case, the AMHP 16 shared cultural identity with the service-user and their family likely shaped their perspective and approach to the assessment. The AMHP's familiarity with the cultural context, values, and norms allowed for a deeper understanding of the service-user's behaviour and circumstances.

The AMHP's ability to challenge assumptions of self-neglect and deteriorating mental health demonstrates how cultural identity can inform professional judgment and decision-making. By acknowledging shared cultural identity, AMHP 16 may have been better equipped to advocate for a culturally informed assessment that considers alternative explanations for the observed behaviours, beyond conventional diagnostic criteria.

In essence, cultural identity theory provides a framework for understanding how the AMHP's shared cultural background influenced their approach to assessing and addressing concerns about the service-user's mental health. This case underscores the importance of cultural competence and sensitivity in mental health assessments, particularly when professionals and service-users share cultural identities.

Interestingly, participants only provided three examples where the views of the person being assessed outweighed the views of family and/or others. In the previous scenario, AMHP 16 delayed making an application to detain. Alternatively, a less restrictive intervention was sought and it was agreed that the Community Home Treatment Team would be utilised and would visit the service-user and offer mental health support in his home. It may be tempting to view the outcome of this MHA assessment as positive. After all, AMHP 16 did not simply accept the perception of others but balanced it with their own views and the views and cultural identity of the person being assessed. This resulted in the views of the nearest relative being outweighed, which then led to a less restrictive outcome. On the face of it this might seem like a typical case, with an appropriate intervention and outcome. However, the person being assessed suffered from a chronic medical condition ancillary to their mental health problems, which required immediate medical intervention, this meant that the person was eventually admitted to hospital. This case demonstrates that the least restrictive option cannot be simply regarded as a straightforward dichotomy of “autonomy versus compulsion” in every situation.

6.3 Implications of non-engagement by the person being assessed

As previously discussed, the process of searching for and gaining an understanding of the person being assessed requires the AMHP to listen to the differing views and stories of others including family, carers and the nearest relative. The AMHP then interprets these views, while also managing any risks and balancing the rights and needs of the person. After having gained an initial understanding of the person from others, the next stage is to undertake an MHA interview, which involves speaking directly to the person being assessed in order to balance their views with the perspectives of others.

It is at this stage in the MHA assessment that the issue of non-engagement by a person being assessed was viewed by participants as significant in terms of inevitably giving more weight to the views and wishes of others than to that of the person subject to the MHA assessment. This is because contradictions in understanding between the views of the person being assessed and those of others are unable to be fully explored. The face-to-face participation of the person being assessed when interviewed is therefore a crucial component of the MHA assessment.

The quote below is an example of the difficulty in achieving meaningful dialogue with a person who does not want to engage in the MHA interview:

‘There was a young Black man that barricaded himself in his house. My decision to detain was based on information I had previously gathered from the nearest relative. The fact that he could not have any form of coherent conversation and would not engage with us made interviewing him impossible. He would just shout obscenities and tell us to go away. Unfortunately, the situation escalated, and the police forced entry, this made the situation worse. He shut down completely and would not talk at all, I got the feeling he was actually really afraid and thought we were there to harm him instead of help him.’ (AMHP 28).

The implication is that although the man’s unusual behaviour did not necessarily manifest during a face-to-face interview, AMHP 28 felt satisfied that the grounds for detention were met. However, this does appear to add an extra layer of difficulty for this participant in matching the presentation of the person assessed to the legal grounds of someone “suffering from a mental disorder of a nature or degree” provided in S2 and S3 MHA. Here, understanding the individual and situation causing concern were understood through the lens of others and the history of the person. The possible outcome for a person who is unable to form meaningful face-to-face engagement and dialogue with the AMHP during the MHA assessment is striking, as it demonstrates how this renders the views of family members as holding more weight.

S13 (2) MHA provides that:

Before making an application for admission of a patient to hospital an AMHP shall interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need.

Notwithstanding the legal requirement to interview the person in a suitable manner, S13 (2) MHA, is also an example of how the MHA informs and structures AMHP practice. Although face-to-face interviews are an integral part of the legal requirements of conducting an MHA assessment, participants described a much more wide-ranging approach to assessment which involved interpreting historical information, cultural and religious beliefs and behaviours, weighing up the views of professionals and family and lastly their own impressions of the person based on the face-to-face interview.

Participants described the difficulties and tensions which arose in satisfying their statutory duty to interview the person in a suitable manner, which was sometimes difficult to achieve. Meaningful dialogue with a person in acute mental distress was often characterised as creating even more distress for the person being assessed. Furthermore, the AMHPs' ability to gain an understanding and interpretation of the person being assessed is usually based on their engagement and demeanor. Some participants recounted examples of what they described as additional "trauma" caused to Black people when their lack of engagement with the MHA assessment process inevitably led to forced entry to the person's home with a warrant. AMHPs still persevered to interview persons in these circumstances despite their inability and/or reluctance to participate in the interview and MHA assessment process. The AMHP is therefore conflicted between disjunctive approaches, that is, coercion and collaboration. Participants have acknowledged that although the events leading to the MHA assessment and the interview are sometimes experienced as a traumatic and coercive event for the person being assessed, there is also a sense of unavoidability that in order to comply with the MHA in practice, coercion is inevitable. This is perhaps indicative of the power imbalance between the AMHP and the person being assessed. The following two quotes highlight that there is a sense of incongruity and tension associated with carrying out the statutory aspects of the MHA interview and AMHPs understanding and engagement with the person subject to the MHA assessment.

"I feel complicit in people's trauma." (AMHP 24)

"To some extent I feel some people are damned by their history. A name is mentioned and you immediately hear from colleagues, that person is this or that...it seems unfair. I find that PICU (Psychiatric Intensive Care Unit) beds are needed more readily for Black men, once a PICU bed is part of your history the risk to others is automatically emphasised." (AMHP 15)

6.4 Stigma attached to social services

Some participants expressed the view that within the wider society there is a stigma attached to social services and social workers. In particular, negative media portrayals which are mostly associated with but not exclusive to children and family social workers have stigmatised social services resulting in people's distrust for social workers. This distrust has extended to other branches of social work such as mental health. Participants commented that the power AMHPs have to detain people under the MHA adds to an immediate perception of AMHPs having unmitigated power and control over people's freedom and choice. Some participants felt that this perceived power imbalance made it especially difficult to communicate with service-users from BME backgrounds and mistrust which created a barrier to communication.

"I think the media has a lot to do with how social workers and AMHPs are perceived. You don't hear any positive stories and because of confidentiality we cannot tell our side. Negative media coverage turns people off of trusting us, they automatically think we are an agent of the State; we are here to take away their rights and freedom. I feel this more so as a White AMHP when

interacting with people who are already discriminated against in society. Why should they trust us?” (AMHP 14)

“I have encountered individuals and entire families who are dubious of social workers on account of stories in the media. As a ‘social worker AMHP’ I feel that the words are stigmatised. I have to clearly explain my role during Mental Health Act assessments and debunk any myths that I am here to take away people’s children and destroy their families. It’s a lot to deal with when there is so much distrust especially when dealing with Black and Asian people.” (AMHP 22)

Participants also acknowledged that it is not only negative stories in the media that have caused this stigmatisation. There are also issues related to experiences of trauma and discrimination that BME people have experienced within wider society and other systems such as policing and criminal justice. White participants shared their personal experience of Black service-users lack of trust of mental health services and AMHPs.

“I assessed a young Black British man who was apathetic throughout the entire assessment. When I asked whether he had any questions about the process he said, “No offence but I don’t trust you lot (White people), you will never understand the Black experience.” (AMHP 17)

“I think one of the main issues we have is that we don’t try to understand why people especially young Black men are angry, why they don’t trust us. So, when you have to deal with a Black service-user or nearest relative, who is angry and distrustful of us, those conversations are uncomfortable, so we label people as uncooperative. It is easier to say, they’re too difficult, they need to be in hospital, let them deal with it. What we should be asking ourselves is, why don’t they trust us? Why are they being uncooperative? Why are they angry? We need to take a step back and ask ourselves these questions. We need to talk about these issues of racism and social injustice but not from a detached way, we need to take them seriously and personally.” (AMHP 29)

The quote above by AMHP 29 supports the idea that if mental health services are to really improve ethnic inequalities in mental health outcomes, then AMHPs and professionals working with Ethnic Minority groups need to take issues such as racism and power indifference personally. The participant makes the distinction that although it is important to take these issues seriously, it is more effective when AMHPs and other professionals take it upon themselves personally to make a difference.

One important thing apparent through the interviews and informal discussions is that this stigma has not been allowed to undermine the AMHPs’ professional performance. All participants expressed that whatever the negative impact the media portrayal of social workers and some people’s prejudices and fears aroused, it had not had a serious influence on their work efficiency. They accepted that they might experience emotional distress during certain incidents; but they had not allowed it to affect the quality of the service

they provide. However, they all personally agreed that there should be more awareness of their role among the wider community.

6.5 Cultural Misunderstandings

According to Wharton (2009) “emotional labour” is the process by which workers (in this study AMHPs) are expected to manage their feelings in accordance with societal expectations and organisational rules and guidelines. Participants reported that tensions between the AMHPs and carers usually arose when a person displayed behaviours, which were considered unusual, and family members struggled to cope or understand them or when differences in cultural norms meant that AMHPs relied on family members or interpreters to advise whether a person’s behaviours and/or beliefs were considered “normal” within that cultural context. AMHPs found it difficult to respond other than by conducting an MHA assessment, usually when there was a lack of meaningful dialogue with the person showing signs of acute mental distress. Additionally, the person was usually referred because they opposed other less restrictive alternatives previously offered.

An example of participants’ perspectives on how emotional labour and adversarial tensions with BME service users and their families could impact MHA assessments are expressed in the following quote:

“I think people are worried about being seen as racist if we question unusual beliefs, we all have levels of unconscious bias within us, but how do you talk about it in a way that's not persecutory?”
(AMHP 6)

S1 (1) MHA provides that the Act has effect with respect to the care, reception and treatment of people who are considered for the purposes of the Act to be mentally disordered, which is described as having “any disorder or disability of the mind” (S1 (2) MHA). An important aspect of understanding the individual being assessed is considering the history of the person along with the co-construction of stories and life-events, which led to their mental health problems. In this regard, participants reported that the interpretation of unusual behavior or beliefs provided context for current concerns. Participants interpreted unusual behaviour and/or beliefs from their own perception about the individual and their circumstances as well as an understanding of the perspective of others such as family, medical professionals and sometimes interpreters. A critical aspect of understanding the perspectives of others, involved participants’ consideration of the impact of unusual behavior and/or beliefs on other people. Interpretation of evidence of unusual behavior and/or beliefs not only contextualised current concerns but provided a basis on which participants justified their action and intervention in terms of the person meeting the legal criteria for the MHA thus providing a rationale for their decision to detain the person in hospital.

However, participants reported that interpreting evidence of unusual behavior and/or beliefs is not a straightforward process and is linked to the idea of what is “normal” or “reasonable” behaviour for the

person being assessed. This was more evident in cases where there were cultural and language differences between participants and the person being assessed.

The following quotes are illustrative of this:

*“Our field of understanding is within the boundaries of what we think is possible or normal.”
(AMHP 3)*

“I assessed a Nigerian woman whom I felt to some extent was great at masking her delusional thoughts. It was difficult as during the assessment she didn’t exhibit any of the usual cognitive aspects of psychosis and was very guarded about her delusional thoughts. Despite her attempt to hide them, her delusions and strange behaviours were still evident and were also recorded in her historical case notes. Through speaking to her I couldn’t tell whether she had any insight into her mental state because she strongly insisted that nothing was wrong with her despite her repeated attempts to harm herself. This was the reason she was unable to keep herself safe while she was in the community.” (AMHP 30)

In this scenario, the behaviour causing concern and the individual being assessed were understood through historical information and the interpretive lens of AMHP 30. Interestingly, during the face-to-face interview AMHP 30 did not apply the “nature or degree” aspect of a mental disorder as set out in sections 2 and 3 MHA as this did not fit with the pathology of the person being assessed. However, the individual was detained under the MHA as their mental disorder was framed as them being guarded and masking their delusional thoughts. This is because the legal criteria were applied to the individual based on a wider perspective which took account of stories told by others and historical case notes. The implication is that the legal criteria for detention under either S2 or S3 MHA can be met based on the AMHP’s perception that the person is masking delusional thoughts supported by relational understandings obtained from other people through previous observations of the person recorded in the case notes. Findings echo those by Kang and Moran (2020) who explored inpatient staff experiences of seeking to meet the religious and cultural needs of BME inpatients on mental health wards. Kang and Moran (2020) found that inpatient staff felt unsure and unprepared to identify and address the religious and cultural needs of BME patient especially those from smaller or new ethnic groups. There was no specific assessment used for these needs, and not all staff had training on addressing the different cultural needs of patients. Staff found it hard to tell if unusual beliefs were religious or signs of delusion. They suggested that family members could help identify and explain these needs and encourage patients to stick to their treatment or medication.

AMHP 30 was prepared to consider alternatives to detention if the person was able to establish a therapeutic relationship with a mental health practitioner. In the face-to-face MHA assessment AMHP 30 determined this was not possible as the person “masked” their delusional thoughts and showed no insight into their mental disorder - therefore compulsory admission to hospital followed. Another implication here is the

importance placed on the person being assessed to demonstrate insight into their psychological state and submit to the view that they are suffering from a “mental disorder.” In this case, the views of the person assessed – “she insisted nothing was wrong with her” were not sufficient and the AMHP relied on information gathered outside of the face-to-face interview such as historical case notes and previous observations of the person. Islam et al. (2015) found that due to cultural and linguistic differences people from Black and Asian backgrounds tend to somatise psychological distress where there is a significant focus on physical symptoms such as pain. This could explain why this Nigerian service-user and other BME people may find it difficult to demonstrate sufficient insight of and acquiescence to having a diagnosis of a “mental disorder” based on their physical experience of mental distress. This focus on somatic symptoms has also perpetuated the myth that people from Black ethnic groups are less likely to engage with or benefit from psychotherapeutic approaches such as talking therapy (Islam et al., 2015).

The existence of distinct ethnic, cultural and linguistic differences between study participants (the majority of whom identified as White British), which surfaced during their accounts of conducting MHA assessments with people from BME groups, were a prominent feature that emerged from the data. These differences go some way towards explaining the reasons why the perceptual and explanatory understandings of mental health across Black ethnic groups differ from those generally held by statutory mental health services. This also raises broader issues regarding the apparent lack of insight into mental illness by Black service users who are perceived to: be reluctant to accept diagnosis and labels of mental illness; somatise their mental distress; demonstrate poor symptom recognition and description; oppose medication and other therapeutic interventions (Memon et al., 2016; Islam et al., 2015). All of which can provide justification for action in terms of the person meeting the legal criteria for compulsion under the MHA.

6.6 The use of interpreters

Memon et al., (2016) asserts that complex emotions and psychological distress require mother-tongue communication, as culturally specific nuances can be lost within the service-user and professional interaction. This assertion has been reflected in the findings of this study where participants expressed that linguistic challenges in MHA assessments were most apparent where English was not the spoken language of the person being assessed or where English was a second language.

“I rely on interpreters to tell me if what the person is saying is normal for their culture.” (AMHP 18)

The quote above reiterates the importance of language in relation to the culturally specific beliefs and norms of people from BME groups during the MHA assessment. Participants expressed that it is important that persons being assessed feel comfortable and confident that their circumstances are understood. In this regard, participants suggested that interpreters help to reduce the risk of misunderstanding during MHA assessments. However, it was clear from participants’ accounts that interpreters interpret more than just

spoken words - they also translate differences between cultures and indicate whether certain beliefs and behaviours were considered “normal” within certain cultural and religious contexts. These cultural differences influence the way people talk about their mental distress and describe their symptoms, which are usually explored in relation to their religious belief systems and cultural traditions.

“During assessments I have come across Black and Asian people and families who have framed mental health around their cultural and spiritual beliefs. They associate the cause of mental distress directly or indirectly to outside forces such as spirits, juju, obeah, curses or magic. Interpreters are sometimes able to help provide insight into these cultural nuances. Personally, I don’t think that these beliefs are understood or respected by most professionals who would think that a person who talked about seeing and hearing spirits was mad. As professionals we use terms such as ‘delusional thoughts’, ‘command hallucinations’, ‘psychosis’, ‘psychotic episode’ and ‘paranoia’ to describe such behaviour and beliefs.” (AMHP 28)

Participants also reported that the use of an interpreter, although useful in linguistically bridging communication gaps through the shared language or cultural background as the individual in mental distress, does not automatically ensure effective communication during MHA assessments. This is because interpreters and service-users may come from different religious or cultural backgrounds, each with their own distinct values and beliefs. As a result, there can be variations in how words, gestures, or expressions are interpreted, potentially leading to miscommunications or misunderstandings during the assessment process.

Furthermore, participants reported that individuals in mental distress have been sometimes reluctant to disclose sensitive information to an interpreter who shares their cultural or religious background. This reluctance may stem from feelings of shame, fear of community judgement, or concerns about confidentiality. As a result, individuals may withhold certain details about their mental state, even when assisted by a proficient interpreter.

These complexities highlight the need for comprehensive approaches to cross-cultural communication in mental health assessments that go beyond linguistic proficiency. Establishing trust, demonstrating cultural sensitivity, and prioritising confidentiality are essential in navigating the challenges posed by cultural and religious differences during interpreter-assisted assessments under the MHA.

The prevailing literature also indicates that BME people do not generally conceptualise mental health in the conventional western bio-medical way which underpins the MHA, English policy, practice and public understandings of mental health (Fernando, 2014; Keating. 2002; DHSC, 2018; Cabinet Office, 2018). AMHPs’ reliance on interpreters to advise and give insight on whether certain beliefs and behaviours were “normal” have implications in relation to AMHPs’ autonomy to determine whether as per section 13 (2) MHA, “an application for the admission to a person in hospital is in all circumstances the most appropriate

way of providing care and medical treatment for the person”. This also poses a question mark over AMHPs’ ability to challenge the bio-medical discourses and psychiatric explanations that underpin their powers of compulsion under the MHA.

6.7 Negative stereotypes of Black people – “Big, Black and Bad?”

“There is a prevailing feeling of dangerousness of Black men.” (AMHP 1)

Tellingly, the quote above taken from the first participant interview conducted in this study, fully captures the essence of the pervading view expressed by the other 30 research participants interviewed. AMHPs expressed that from their experience, young Black men are more likely than any other group of service-users to end up with a racialised profile of their mental health. This is because “uncooperative behaviours” by Black men were often implicated in the stereotypical perceptions by some mental health professionals that Black men are aggressive, more prone to violence, cannabis-smokers or schizophrenic. Participants talked about how racial stereotypes could create barriers for Black people accessing mental health services and for those that accessed services, these stereotypes could influence diagnosis and the type of treatment and support offered.

6.7.1 The Orville Blackwood Inquiry (1993)

Worryingly, this pervading perception by professionals that Black people, in particular Black men, are dangerous has not changed almost three decades on from the 1993 Orville Blackwood Inquiry, and subsequent report of the committee of inquiry into the death in custody of an African Caribbean man, Orville Blackwood at Broadmoor Hospital in 1991. Orville Blackwood died following the culmination of systematic failures, which resulted in him being restrained and forcibly injected with a lethal cocktail of antipsychotic medications. The inquiry also highlighted the cases of two other Black men of African Caribbean decent, Michael Martin and Joseph Watts who suffered similar fates and died while under the care of Broadmoor Hospital (Prins, 1993). “Big, Black and Dangerous?” was a phrase coined by the committee of inquiry and used as the subtitle of the report (albeit with a question mark) due to the number of times the phrase was used by staff at Broadmoor Hospital to describe Black mental health patients. The report detailed how Black patients were more likely to be: compulsory detained under the MHA; have police involved in their admission; be diagnosed with schizophrenia, receive treatment in a locked psychiatric ward; less likely to receive psychotherapy; subject to physical treatments; given higher doses of medication and be restrained or secluded (Prins, 1993). Broadmoor Hospital was criticised for its poor nursing skills, insensitivity towards patients by staff, lack of management guidance and its knee jerk reactions to uncooperative behaviours by patients. However, both covert and overt organisational racism, such as the stereotyping and prejudicial perceptions held by staff that Black patients were “big, Black and dangerous” were implicated as playing a significant role in the deaths of these men (Victor, 1996; Prins, 1993; Crichton 1994).

The Orville Blackwood committee of inquiry put forward 47 recommendations for preventing these incidents from reoccurring. Included in the recommendations was a revision of staff recruitment policies to include the representation of BME staff at a management level within the hospital as well as developing race awareness training (Prins, 1993; Crichton, 1994). Despite the mental health team at Broadmoor not taking all 47 recommendations on board, this report was pivotal in highlighting the role of race and ethnicity in treatment and outcomes, where Black people, in particular Black men, were most likely to have negative experiences and were most vulnerable to racial stereotyping and discrimination within mental health services.

These more punitive and restrictive forms of treatment meted out to Black people have been linked to raised rates of involuntary detention under the MHA. For over four decades the issue of race in relation to British psychiatry and associated concerns of its impact on the over-representation of people from Black and Minority Ethnic groups in the more coercive pathways into the mental health system has been highlighted throughout the literature, (Littlewood & Cross, 1980; Rogers and Faulkner 1987; Mason 2000; Prins 1993; Keating et al., 2002; Edge and MacKian, 2010; Memon et al., 2016; Barnett, 2019).

These issues are not exclusive to the mental health system but are also mirrored within the CJS. The latest figures show that when compared to White people, Black people are more likely to be subjected to stop and search by police - 7.5 stop and searches for every 1,000 White people, compared with 52.6 for every 1,000 Black people (gov.uk, 2022); custodial remand – 40 percent of White defendants remanded in custody compared to 49 percent of Black defendants (Ministry of Justice, 2021) and psychiatric disposal (Centre for Mental Health, 2013). The evidence shows that Black people are subjected to more psychiatric and criminal detention when compared to White people and are consequently disproportionately represented within psychiatric hospital and prison populations. Moreover, in England and Wales, despite representing 3 percent of the total population, Black people account for 13 percent of the prison population (Ministry of Justice, 2021) a figure four times greater than their proportion in the general population.

It seems undeniable that Black people are subjected to the harsher more coercive end of treatment in both the criminal justice and mental health systems. Boast and Chesterman (1995) argue that psychiatric services along with the CJS appear to work together in concentrating the numbers of Black people within secure psychiatric hospitals. However, Boast and Chesterman (1995) also argue that the phenomenon of over-representation cannot be explained by a simple theory based solely on the assumption of racial stereotyping or racist practice by professionals. There is a hugely complex picture where multiple factors and their interaction need to be considered. These factors will be explored in more detail in the discussion chapter of this study.

6.8 Ethnic inequality within the workforce: Underrepresentation of Black and Minority Ethnic AMHPs and mental health professionals

The final theme in this chapter is focused on ethnic inequalities within the AMHP workforce. BME participants talked about their personal experiences and challenges in the context of being in the minority as a Black, Asian or Minority Ethnic AMHP in relation to their White colleagues. However, White AMHPs reflected on the experience of having to be careful with how they brought up issues of race amongst their BME colleagues and service-users. According to the latest published AMHP workforce data 73 percent of social workers identified as being of White ethnicity and 27 percent identified as being of an ethnicity that was Black, Asian, Mixed or Minority Ethnic (Skills for Care, 2022). Social worker AMHPs were less ethnically diverse with 21 percent BME social worker AMHPs overall. London showed the highest ethnic diversity with 60 percent of social workers and 55 percent of AMHPs from BME backgrounds. Whereas, in the North-East where this study's participants are based, diversity was lower with 6 percent of social workers and AMHPs from BME backgrounds. However, these proportions generally reflect the population of these regions (Skills for Care, 2022).

6.8.1 Lack of ethnic diversity within AMHP workforce

“Our workforce is not diverse so it's not always the case that you'd have other colleagues who can identify with BME service-users in terms of culture, language or religious beliefs.” (AMHP 22)

As seen in the quote above, the data reveals examples in which participants explicitly draw attention to the fact that due to the lack of ethnic diversity within their team, it is difficult to seek advice from BME colleagues with lived experience of matters concerning the culture, beliefs and customs of people from BME groups.

On the other hand, Black participants expressed concerns about the burden of being in the minority in a team of mostly White colleagues.

“I find that as a Black person there is always this assumption that I am knowledgeable about all things Black...actually I am not...it's quite tokenistic and isolating.” (AMHP 17)

“Because there aren't very many Black AMHPs you feel like you have to represent and speak up on BME and diversity issues more than you would like to, being in the minority comes with its challenges but you can't help how you are viewed by others you can't escape the role, it's kind of expected.” (AMHP 5)

It could be argued that the underrepresentation of BME staff within the AMHP workforce and mental health services generally serves as a barrier to thinking, speaking openly about as well as addressing ethnic inequalities within the workforce. The participant below identified this issue.

“The thing is, you can appear to have a diverse workforce on paper without having any meaningful diversity. You know, management could do a recruitment exercise and hire Black and Minority Ethnic AMHPs and everyone then feels that the checkbox is ticked and the workforce appears quite diverse, but actually what we need to ask is, are the voices and ideas of the minority being heard?”
(AMHP 29)

The impact of ethnic inequality within the AMHP workforce is particularly evident when it comes to driving, influencing and implementing change at more senior levels within AMHP services.

“How are teams expected to affect real change regarding issues of diversity when the majority of managers, senior leaders and clinicians are White?” (AMHP 9)

The concern here was that the underrepresentation of BME or Black AMHPs at senior levels within the AMHP workforce, presented an additional challenge in terms of having real and meaningful power and influence within AMHP services to make changes in terms of prioritising ethnic inequalities in the workforce. BME participants feared that initiatives aimed at tackling ethnic disparities became either lost or subsumed under broader equality and diversity agendas and workforce initiatives which sought to address more general anti-discrimination practices and policies. Similarly, Salway et al. (2016) identified barriers to achieving race equality within healthcare in England were linked to ambivalence from senior policy makers and lack of attention concerning issues of race within practice and policies.

“Although racial disparities are spoken about a lot in diversity training, I still feel that addressing these issues doesn’t feel embedded in our processes and procedures....” (AMHP 16)

Salway et al. (2016) also found that developing an ethnically diverse workforce, having senior staff with clearly defined remit for equality and diversity, as well as policies which embed the importance of individual agency by professionals in tackling racial inequalities, were practical ways of supporting and promoting race equality within healthcare.

6.8.2 Workforce initiatives

Almost all participants were aware of at least one workforce initiative currently being carried out within their AMHP service with the aim of improving outcomes for BME service users and/or staff. Among the initiatives mentioned were cultural competence training and BME staff networks.

Most participants reflected on the impact of ethnic inequalities within the AMHP workforce on MHA assessment outcomes for Black service-users. In particular, the ruling relations and power imbalance that come with belonging to an Ethnic Minority group and highlighting how decisions made by people belonging to the majority ethnic group for example White clinicians made it difficult to adequately address the issues about the impact of racial discrimination. White participants expressed that they avoid speaking

to both colleagues and BME service-users about race due to the sensitive nature of the topic, which often arouses feelings of discomfort underpinned by fears of “saying something wrong” or being viewed as racist. On the other hand, BME participants talked about not wanting to appear too “preoccupied with race” which could make White colleagues feel uncomfortable and could also be viewed as racist. BME participants also spoke about having to think carefully about how they spoke about race, to avoid being branded as the spokesperson for these issues. Participants were mindful of potential professional and ethical issues, which may arise from focusing solely on race when it comes to addressing issues of equality and diversity. Participants highlighted the importance of acknowledging the multiple and sometimes complex identities that both practitioners and service-users carry in addition to their racial identity.

6.8.3 Implications for AMHP policy and practice

Drawing on the relevant literature, I will briefly summarise the broader implications of these findings on AMHP policy and practice, including recommendations put forward by the participants.

This study found that engaging AMHPs in meaningful discussions about strategies to address equality and diversity and the impact of racial discrimination on both staff and service-users requires a culture where these issues are openly and confidently spoken about. Opportunities for all AMHPs to reflect on policies and practices in which racial equality is embedded should be prioritised thus providing safe spaces in which AMHPs could reflect and speak openly about race without fear of victimisation or “political correctness” (Griffiths, 2009; Bhavnani et al. 2005). According to Griffiths (2009), this approach should enable staff to recognise that despite the sensitive and deep emotions often evoked when talking about issues of race, there should be individual agency regarding these matters and the onus should not be placed on Black staff to be the mouthpiece and take on this responsibility.

Chapter 7. “Is it a crime?”

This chapter moves on from the participants’ accounts of the MHA assessment interview to the third stage in progressing an MHA assessment – the decision and outcome. It deals with participants’ description of the resources and professional relationships encountered during the decision-making process. The challenges to AMHP autonomy emerge through this chapter’s consideration of the tensions within multidisciplinary and inter-agency work. These findings highlight the socio-relational context of AMHP work with other professionals. As with previous results chapters, I draw on the words of a participant who asks, “Is it a crime?” in relation to their view of disproportionate police involvement in S135 (1) or (2) warrants after an application for detention is made, particularly when Black people are subjected to police restraint and control as part of an MHA assessment and detention process.

7.1 Tensions with multidisciplinary and interdisciplinary working

7.1.1 AMHPs working relationship with section 12 doctors

Ideally, MHA assessments should be undertaken jointly (the AMHP plus two appropriate doctors) as this ensures the person is not subject to repeated assessments and allows for a sharing of risk and professional judgement (Stone et al., 2020). When discussing multidisciplinary and interdisciplinary working with other professionals and agencies, participants identified their working relationship with the independent S12 (2) doctor as a significant resource. The independent S12 (2) doctor is usually chosen by the AMHP to take part in the assessment and is more than likely to have had previous acquaintance with the AMHP because they are usually on an organised rota.

On the other hand, the other doctor, usually from an NHS Trust, is usually the referring doctor with responsibility for making a first medical recommendation. This working relationship for most participants was discernibly less significant. Participants gave two main reasons why their working relationship with the independent S12 (2) approved doctor was more significant. Firstly, in choosing an independent S12 doctor, AMHPs sought the best fit in terms of the clinical needs of the person being assessed and the best fit for them (the AMHP) in terms of a working relationship. Secondly, there is sometimes a requirement to match the expertise of the independent S12 doctor with the characteristics and needs of the person being assessed. However, there was also a clear sense that the nature of the working relationship between AMHPs and the independent S12 doctors was a significant factor in determining which doctor was chosen by participants to accompany them during the MHA assessment, notwithstanding choice constraints as S12 doctors are usually selected from rotas. Participants valued interdisciplinary and inter-professional working relationships where there was an acknowledgement and mutual respect for each professional’s role and responsibilities (especially the AMHP) in the MHA assessment process.

In England, 56 percent of NHS doctors (there is no reported data on the ethnicities of psychiatrists specifically) are from White ethnic groups whereas 5 percent are from Black ethnic groups (gov.uk, 2020). This reflects participants' experience of limited availability and interaction with Black S12 doctors. Participants reflected on the low numbers of psychiatrists from Black ethnic groups during interviews, given the increased likelihood of people from Black ethnic groups being detained after an MHA assessment. Participants reflected that a general lack of Black S12 doctors meant that the medical workforce does not reflect the ethnic diversity of people accessing mental health services. Participants felt this could be a problem in some situations when involving Black S12 doctors might be preferable, as seen from the example quoted below:

“There is a complete lack of Black section twelves (S12 doctors). However, a few months ago, there is me, two Black male section twelves, one Black African and the other Black British. The person we were assessing was a Black British man who had past issues of trauma involving White men. At the end of the assessment, I thought it was incredible, because it has never happened before (2 Black S12 doctors). For me, it was important that you know, in a multi-cultural, multi-ethnic society the mental health and medical workforce should reflect the people who use our services. Then people are able to interact with professionals who share a similar cultural identity. I think this is especially important for Black and Minority Ethnic people.” (AMHP 20)

There is no data on the ethnicity of psychiatrists or S12 doctors and this would be helpful to collect not only for research but also for equality and diversity purposes. Many participants expressed that it would be useful for S12 doctors to have training in cultural awareness, particularly as it pertains to data on the longstanding disproportionate detention of Black people under the MHA.

7.1.2 AMHPs' working relationship with the police

Participants also discussed their working relationship with the police as key, especially where police involvement and MHA S135 (1) or (2) warrants are required. Participants' views on their relationship with the police were mixed with some describing the support and interaction with the police as positive and others who found there were sometimes tensions when working with police and some medical professionals. Participants expressed that police and medical professionals all had different approaches for prioritising and risk assessing mental health work based on their own internal policies, professional judgements and thresholds. Participants found this aspect of inter-agency and multidisciplinary work challenging, expressing particular concerns around the ability to maintain their professional identity and autonomy as an AMHP in these circumstances. Participants also discussed the apparent resentment of some Black service-users to police involvement in MHA assessments due to the Police service's consistent pattern of institutionally racist behaviors, which extends from racial stereotyping and profiling, disproportional stop and search, harsher prosecution policies through to the use of excessive force and restraint all targeted toward people from Black ethnic groups.

Concerns regarding "risk" in the context of an AMHP requesting police attendance during an MHA assessment are often centred on the imperative to ensure safety and effectively manage potential threats throughout the assessment process. The decision to involve the police typically reflects the AMHP's evaluation of the potential risks posed by the individual under assessment or the circumstances surrounding the assessment. However, various factors may contribute to an AMHP's decision to request police presence during an MHA assessment.

Participants reported that when co-ordinating the MHA assessment, they will seek the cooperation of the person being assessed. In some cases this is not possible due to lack of engagement by the person being assessed and where there are concerns for the safety of themselves and/or others. For example, in situations where the individual's behaviour or circumstances present complex or ambiguous risks, the AMHP may seek police support to maintain control of the situation and conduct a comprehensive assessment. In these cases, AMHPs apply to the magistrate's court for a warrant issued under S135 (1) MHA. Once signed by the police officer present, a copy of the warrant is provided to the person being assessed or their nearest relative. This allows the AMHP, one or two doctors and a police officer to enter the home by force if the person to be assessed still refuses to have any form of contact. Participants also reported that they can also remove the person to a place of safety to continue the assessment. Participants reported that they will only take these steps when there is enough evidence that all possible attempts to engage with the person to be assessed has failed. The MHA assessment can take place in a person's home if they agree and the AMHP and other professionals in attendance believe that there is no risk to themselves or others. Additionally, broader community safety considerations may come into play, particularly if the individual's behaviour poses risks to others in the vicinity. A S135 (1) MHA warrant lasts up to 24 hours but, on occasions, a doctor can grant an extension for a further 12 hours.

The flowchart presented in Figure 10 depicts findings which show how risk concerns are linked to the decision-making process that leads to the requirement for police attendance at MHA assessment. This flowchart enhances understanding of the interrelationship between risk assessment, safety considerations, and the requirement for AMHPs to fulfil their statutory duty within the context of MHA assessments.

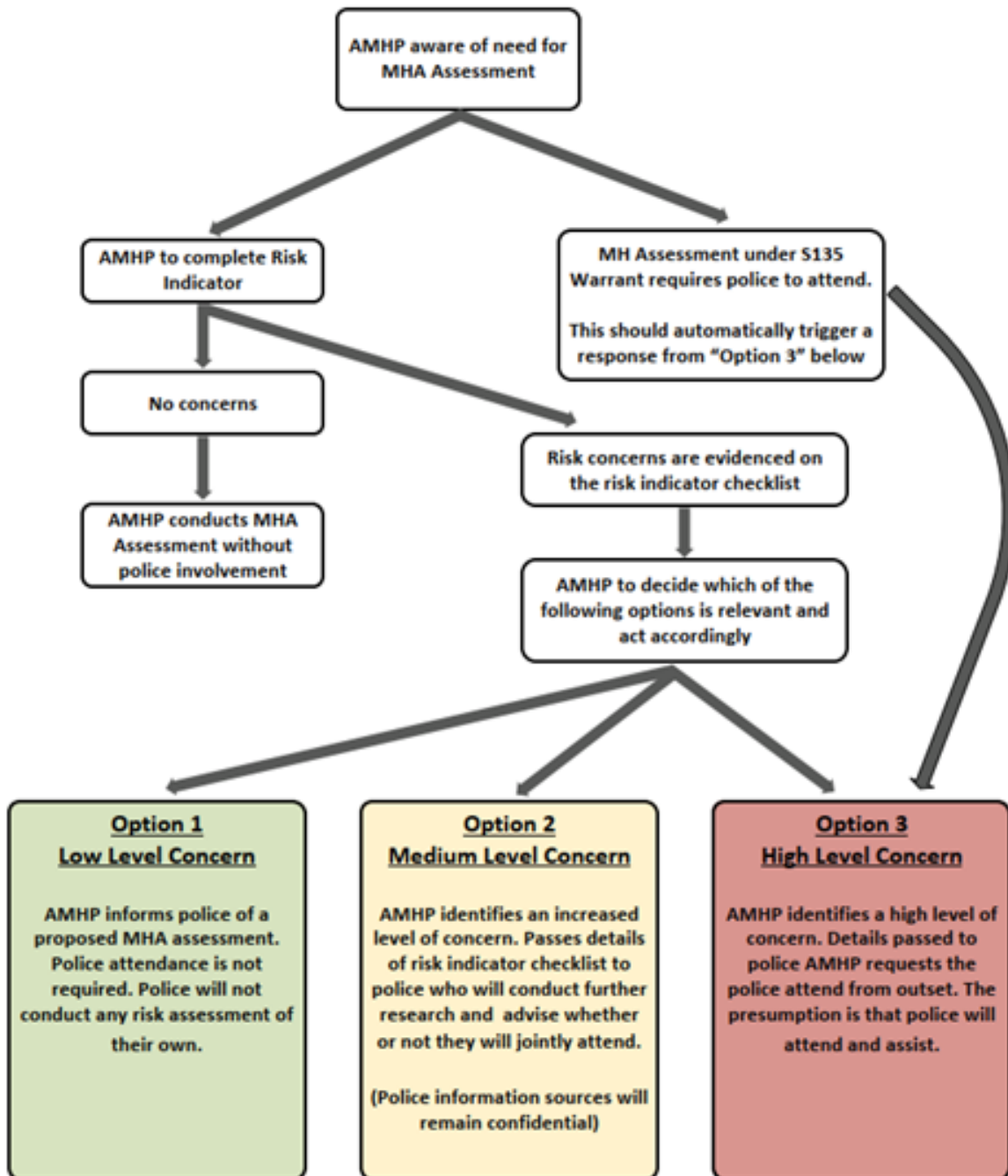


Figure 10. Flowchart showing how risk concerns are linked to requirement for police attendance at an MHA assessment

7.2 Professional identity and autonomy as an AMHP

All participants spoke of the importance of autonomy in their role as AMHPs. The notion of autonomy was closely linked to participants' inter-professional and inter-agency working relationships. Participants viewed their autonomy as a significant resource, which gave them full authority to disagree and take an opposing view to the medical professional involved in the MHA assessment or contrastingly, autonomy was used as a resource to share a mutual view about a service-user as the medical professional. For participants, the concept of their autonomy as AMHPs was emphasised by the fact that notwithstanding their right to agree with the views of medical professionals they equally reserved the right to disagree, in other words, the potential to disagree or have a contrasting view was of significance importance to AMHPs.

The quote below shows how important the concept of autonomy is to AMHPs in terms of the potential to have differing views or disagree with medical professionals:

“A doctor phoned me to query my decision not to make an application involving a Black man who had been previously detained, he said, ‘I thought if an AMHP had 2 medical recommendations you must make an application.’ We still hear that today, the theory is we should sign it off because the doctor says to. It’s like no, we make the decision, not you...” (AMHP 4)

The participant below viewed AMHP's autonomy as a source of great “power” in the MHA assessment process but viewed AMHPs as having the least power in terms of their professional identity and hierarchy amongst medical colleagues,

“The AMHP has the most power but the least power in hierarchy.” (AMHP 24)

7.3 Issues with inter-agency working

The need for an inpatient psychiatric bed arises when an AMHP decides to make an application to detain a person under the MHA. This can only be made possible when the responsible NHS hospital trust makes a bed available in a named hospital. According to the MHA Code of Practice, it is entirely the doctor's responsibility to find a bed and the MHA provides that it is the duty of the hospital trust to provide the bed.

Despite the clear demarcation of responsibilities in terms of finding and locating an inpatient psychiatric bed, participants spoke about often finding themselves in situation where they were actively searching for a bed as they intended to make an application for detention. This situation arises when the doctor on whose medical recommendation the application for detention was founded, does not carry out their responsibility to locate a hospital bed. Participants pointed out that this issue is further compounded by the lack of psychiatric beds in their area. Twelve participants expressed concerns about the steady decline and unavailability of local psychiatric beds. They recalled cases where persons detained under the MHA were

admitted to hospitals in geographical areas outside of the borough where the AMHP worked because of a shortage of beds.

When asked about their views on what sort of impact the issue of a chronic shortage of psychiatric beds had on Black service-users, participants found that placing a person who already had limited social capital in terms of a familial support system “out of area” hospital placement is problematic. This was viewed both in terms of the experience of the person who is far away from family, friends and their wider community and for the AMHP, who may be faced with factoring in how a person would get from a hospital in a distant geographical location back to their home if they are not detained and be repatriated with their family.

“When people from close-knit Minority Ethnic communities with limited support systems are detained and hospitalised far away from their family and friends, away from their local community, shops, food....do we expect them to get better? What do we expect to happen?” (AMHP 11)

“All too often some doctors wash their hands of the situation and have no idea where the (hospital) bed is. I have to remind them that it is not my job to secure a bed for the patient; it is the doctor’s responsibility. Some doctors will dump that responsibility on us and leave us to get on with it if we are not careful.” (AMHP 5)

7.4 Conveyance to hospital

When discussing arranging conveyance Stone et al. (2020, p. 83) argue, “this is probably one of the most difficult areas of AMHP practice.” When coordinating an MHA assessment, the AMHP has to consider the most appropriate means of conveyance. According to the MHA Codes of Practice, the AMHP has a professional responsibility to ensure all the required arrangements are made for the person to be conveyed to hospital (Department of Health [DH], 2015). Of the two LAs that participated in this study, AMHPs in local authority B had access to a dedicated conveyance service that was commissioned through the NHS trust and had significantly reduced the need for police involvement in the conveyance of persons to hospital on completion of an MHA assessment. On the other hand, AMHPs in local authority A did not have access to a dedicated commissioned conveyance service and relied on NHS trust ambulances to convey persons to hospital. Participants in local authority A expressed frustration at not having any control over ambulance response times and shared stories of having to wait in excess of five hours for ambulances to arrive. Additionally, AMHPs also had to work with some ambulance crew who were reluctant to deal with persons in acute mental distress. One ambulance crew member remarked to a participant that they felt like “a glorified taxi service” regarding conveying persons sectioned under the MHA to hospital. Participants felt that this view is mainly due to the ambulance service’s historical prioritisation of persons with acute life-threatening conditions such as heart attacks over persons in acute mental distress.

Given the limited bed availability persons detained under the MHA are often conveyed to hospitals a long distance away from their local communities to what in most cases is the only available bed in the country. This raises particular disadvantages for people from racialised communities, as Black service-users who are detained in psychiatric hospitals far away from their towns and neighbouring districts are cut-off from their local communities and further isolated which in some instances leads to a worsening of mental distress.

7.5 The impact of social isolation on Black mental health

Zavaleta et al. (2014, p. 67), describe social isolation as: “a deprivation of social connectedness...social isolation is the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).” Whereas Biordi and Nicholson (2013, p. 97) define social isolation as “the distancing of an individual, psychologically or physically, or both, from his or her network of desired or needed relationships with other persons...social isolation can be voluntary or involuntary.”

Participants discussed the powerful role that social networks and relationships play in service-users’ psychological wellbeing and overall mental health. Participants said that during the MHA assessment process they often observed that people from racialised communities, in particular, Black service-users were inclined to have small, tight cohesive social entities such as church and immediate familial support when compared to White and other Minority Ethnic service users who were inclined to have wider support networks such as extended familial support. Participants found that for Black service-users, their ecological social capital (Putnam, 2000) which relates to the quality of social networks, access to resources and participation in social activity, family support and confiding relationships, were often found within their local communities. Hence, the detention of Black service-users to hospitals which were significantly distant geographically from their homes and local community, were seen as a form of involuntary social isolation which is further implicated with the exacerbation of mental distress for people from Black ethnic groups.

Brooks et al. (2020) found that periods of social isolation, even less than 10 days, can have long-term detrimental effects on a person’s mental health, with psychiatric symptoms manifesting up to three years after the period of isolation. Participants reported that the mental health consequences of enforced social isolation as a direct consequence of national lockdowns during the COVID-19 pandemic are already visible. This is evidenced by the ‘MHA Statistics, Annual figures 2020/2021’ (NHS Digital, 2021) which has reported a 4.5 percent increase in compulsory detentions under the MHA during the period 2020/2021. People from Black ethnic groups continue to be disproportionately detained under the MHA with rates of detention over four times those in White ethnic groups. Use of Community Treatment Orders were over ten times the rate for people from White ethnic groups (NHS Digital, 2021). These statistics show a widening of what is already a significant mental health gap for people from Black ethnic groups. Additionally, in the UK, high rates of social isolation are prevalent in people from BME groups (Salway et al., 2020). Therefore,

these groups face specific risks, leaving them susceptible to developing psychological disorders (Strang & Quinn, 2014).

This theory is also supported in the literature where previous studies have identified a direct link between social isolation and psychological disorders (Beller & Wagner, 2018; Han & Richardson, 2010; Cacioppo et al., 2006; Luanaigh & Lawlor, 2008) in particular: eating disorders and digestive problems (Rogers et al., 2020) personality disorders (Richman & Sokolove, 1992), psychoses (DeNiro, 1995) and suicidality (Goldsmith et al., 2002; Hom et al., 2017). Social isolation has also been linked to a lack of insight (White et al., 2000), higher levels of delusions (Garety et al., 2001) and increases in length and frequency of hospital admissions (Hawker & Romero-Ortuno, 2016; Mgutshini, 2010) among people with severe mental illness. Conversely, people who do not experience social isolation and have greater social capital and social support have been found to have lower hospital admissions and are more likely to recover from psychotic symptoms (Calsyn & Winter, 2002)

7.6 Disproportionate police involvement

Police can be involved in MHA work when a person is detained under S136 MHA and taken to a place of safety or when a warrant is required under S135(1) or S135(2). Similar to ambulance services which prioritise persons with acute life-threatening conditions, AMHPS have expressed similar issues with police challenging the legality of their attendance at MHA assessments and prioritising work that is non-mental health related. The implication of this is that if an AMHP anticipates that there may be a risk of violence at an assessment they can request a S135(1) warrant as a safety precaution, however, if violence or aggression that cannot be safely de-escalated is experienced during the MHA assessment the AMHP and any accompanying professionals will need to retreat and call for police assistance. Stone et al. (2020, p. 81) assert, “requests for warrants are becoming more commonplace as the police are challenging the legal framework underpinning their attendance at an MHA assessment without one.”

Participants indicated that police involvement was sometimes instigated by family members rather than AMHPs themselves. Participants spoke of the need for greater engagement, cooperation and awareness between AMHPs, the police and ambulance service:

“Although I can seek a warrant to enter someone’s home, I cannot instruct or dictate when the police should turn up, the same with conveyance, without a dedicated conveyance service I rely on an ambulance to convey someone from their home to hospital however, I have no control over when that ambulance would or should arrive.” (AMHP 13)

“Police are reluctant to step in if there is no warrant, they don’t see it as their role.” (AMHP 5)

7.7 Use of restraint and/or control tactics by police during MHA assessment

Participants were asked how they managed risk and proportionality when engaging with the police notwithstanding the history of institutional racism within the police service as well as the long list of incidents involving Black men who have died after being forcibly restrained in police custody and in psychiatric hospitals.

Participants expressed concern over the disproportionate use of tasers on Black people and particularly those who were in obvious mental distress. Participants gave accounts of instances where they felt that harsher restraint techniques were disproportionately used against young Black men, whose disorientation and mental distress was more often than not stereotyped as violence and aggression. Participants expressed that disproportionate police involvement only served to fuel distrust, exacerbate mental distress and provoke uncooperative responses from Black people experiencing a mental health crisis.

“It seems to me to be a vicious cycle of the discrimination that Black men face with police when compared to things like ‘stop and search’. This is no different, police use of restraint is noticeably different when dealing with young Black men, I’ve seen tasers used to subdue a Black man in mental distress, I’ve never seen it happen to a White person. Then people wonder why Black people don’t trust the police, why they don’t trust us, why they lash out. When I see this sort of disproportionate police involvement, I ask myself, is it a crime? Is having a mental health crisis a crime?” (AMHP 12)

“I had an assessment where I requested police assistance when a young mentally distressed Black man who threatened to jump from the top window of a two-storey house. You could imagine my shock when four squad cars with sirens blaring showed up to the home of this young Black man armed to the teeth with visible firearms, tasers and noisy walkie talkies. Apparently, this man was previously known to police... Of course, this aggravated an already volatile situation and the young man was tasered in order to subdue and restrain him. Although I requested their support I didn’t agree with this course of action by the police and found their presence and use of force disproportional.” (AMHP 11)

During the MHA assessment process, if based on a risk assessment completed by the AMHP, control or restraint is deemed to be appropriate and required the AMHP decides who is going to be asked to use restraint. In the absence of a dedicated commissioned NHS Trust conveyance service participants from local authority A relied on the police and ambulance service for conveyance and restraint of persons detained under the MHA. Participants viewed their most concerning collaboration with police occurs when police officers attended MHA assessments to assist ambulance crew in restraining persons detained under the MHA and requiring conveyance to psychiatric hospital. This was particularly problematic as the police

and ambulance service often used their own intelligence and/or algorithm to decide both priority and level of risk. Participants recalled specific cases of MHA assessments involving Black service-users who were previously known to police. Calls to emergency services and the police response that followed was often disproportionate with the use of forceful types of restraint – in particular, use of tasers, handcuffing and arm and leg locks. Home Office statistics on the number of detentions under S136 MHA, Police Powers and Procedures for the period 2020/2021 (gov.uk, 2021a) recorded 33,652 uses of this section in England and Wales 2,262 or 9 percent of those detained were Black.

Police service statistics for 2020/2021 report that the overall use of force tactics ranging from handcuffing and ground restraint to the use of batons, tasers and firearms, involved people perceived as being from a Black ethnic group at a rate 4.6 times higher than people perceived as being from a White ethnic group in police force areas in England and Wales (excluding the Metropolitan Police). In the Metropolitan police force area, use of force tactics involved people perceived as being from a Black ethnic group at a rate 4.0 times higher than those perceived as being from a White ethnic group (gov.uk, 2021b). These statistics are indicative of the main trends and patterns in police uses of force. When compared to the longstanding statistics which report the continued disproportionate detention of Black people under the MHA, one may argue that the discriminatory rationale that underpins use of force in policing may also be operating in parts of the mental health system, this argument will be further explored in the discussion chapter of this thesis.

Chapter 8. “A cheeky look”

This short chapter presents the findings derived from participants' accounts of the fourth and final phase of the MHA assessment process - post-assessment requirements. It explores participants' consideration of opportunities to critically reflect of their practice and factors that impact their decision-making. These opportunities include post-assessment peer discussions, feedback from service-users regarding their assessment experiences, and following up on outcomes for individuals assessed under the MHA, particularly marginalised groups and those detained under the MHA.

During interviews, several participants used the phrase "I take a cheeky look" to describe how they monitored and tracked cases of individuals they had assessed under the MHA. Given the absence of a formal mechanism within the MHA assessment process to follow-up on individual cases or access electronic case files post-assessment, participants resorted to informally accessing electronic case records hence describing their actions as having a “cheeky look”. This practice was motivated by various reasons, which will be elaborated upon in this chapter. The specific research question addressed in this chapter is:

To what extent are the accounts of social worker AMHPs “actual” experiences of coordinating MHA assessments with Black service-users representative of the “ideological” work of AMHPs (are some things unaccounted for? This research question is instrumental in exploring the nuanced aspects of AMHP practice, the intersectionality of decision-making processes, and the implications of these practices on marginalised populations, specifically Black service-users within the context of MHA assessments. These findings shed light on the multifaceted dimensions of AMHP practice and contribute to a comprehensive understanding of the challenges and considerations inherent in this critical area of mental health social work.

8.1 Lack of feedback from service-users

Participants expressed that the current MHA assessment process does not allow for feedback from service-users, carers or nearest relatives on AMHPs' application and use of the MHA. Participants reflected on the fact that persons subjected to an MHA assessment do not get a copy of the assessment and are not given the opportunity to make changes, factual or otherwise to information obtained in the referral or assessment. The AMHP duty system also means that most participants do AMHP work once per week alongside their social work caseload. Participants felt that given pressures faced by the social work “day job” there is not time after an MHA assessment to seek feedback from service-users, carers or nearest relatives. Participants viewed the lack of opportunity for service-users to provide feedback on the MHA assessment or receive a copy of the assessment reflects an inherent power imbalance within the MHA assessment process. Participants expressed that lack of feedback can also be seen as contributing to the ethnic disparities in detention rates.

8.2 Accessing information after an MHA assessment

One of the findings from this study was that there are no standardised ways for AMHPs to collect, monitor or analyse the outcome of their decisions to detain a person under the MHA. What this means in practice is that the opportunities to identify disparities in MHA assessment outcomes are contingent on the resources and systems available within a particular AMHP service, as well as the practices adopted by individual practitioners. Participants frequently used the term “taking a cheeky look” to describe the practice of accessing case records of a person whom they had previously sectioned to ascertain the eventual outcomes for persons. The implication is that until there are standardised ways of collecting, monitoring and analysing this information, AMHPs would not be in a position to identify, make sense of or address any disparities in their decisions to detain or not detain people under the MHA including those most marginalised. Additionally, by “taking a cheeky look” at the case records AMHPs may risk breaching the General Data Protection Regulation [GDPR] (European Commission, 2023). GDPR breaches include looking at more information than necessary about a service user, or knowingly requesting (and obtaining) access to information that is not relevant to their role.

8.3 Lack of opportunities for formal follow-up after MHA assessment

Participants expressed that current processes do not provide opportunities for service-user follow-up after an MHA assessment. In particular, participants felt that providing an opportunity for AMHPs to follow-up with service-users and/or their carers after involuntary psychiatric hospitalisation may improve service-user outcomes and decrease the likelihood of re-hospitalisation. There are several findings in the literature that are also relevant to improving ethnic disparities through professionals following-up with service-users. For example, Gillispie et al. (2005) found that amongst Black inpatients, their intent to engage with mental health services after inpatient treatment is influenced by the level of empathic understanding they receive from mental health professionals during the hospitalisation. Participants felt that a culturally competent mental health care of Black patients might include efforts by both AMHPs and inpatient staff to use brief psychotherapeutic approaches to convey empathy. Participants felt that collaborative-care approaches where AMHPs were given the opportunity to follow up on in-patient outcomes may help individuals from Minority Ethnic groups especially, to engage in their outpatient mental health treatment and ultimately reduce the likelihood of their readmission to hospital. Participants wanted the best outcomes for individuals sectioned under the MHA and were curious to know whether they were okay or how they got on:

“I want to see how my decision develops and have impacted someone’s path.” (AMHP 25)

“There is no follow up, how do we learn from our decision?” (AMHP 29)

“It will be useful to learn from people going through the experience of being sectioned.” (AMHP 20)

Participants were asked to describe what follow up would look like if included as part of the MHA assessment process. Participants described follow-up as a process whereby if appropriate to do so, an AMHP would make contact with a service-user or carer at a later, specified date ideally within 30 days after an MHA assessment to check on the service-users' progress since the assessment. Participants saw follow up after an MHA assessment as a means to help identify the impact of their decision to detain or not detain a person under the MHA or get feedback and learn from people's experience of the MHA assessment process. In addition, participants felt follow up could help to promote a good relationship between AMHPs and service-users which may improve health outcomes and prevent readmissions for overrepresented groups such as people from BME groups. Participants expressed that it is understandable given pressures faced by AMHPs who deal with inherent distressing aspects of social work practice follow ups with service-users may not be practical within current AMHP work processes.

Chapter 9. Discussion

9.1 Chapter overview

In previous chapters, the research findings were presented by following the process of the MHA assessment and analysing the emergent analytical themes. This chapter integrates these findings and discusses how they relate to the relevant literature. I discuss the research findings through the lens of *ruling relations* (Smith 2005) reflecting on the role of the MHA and Code of practice in shaping the decision-making, from the standpoint of AMHPs. Specifically, I illustrate that this study's findings are consistent with the current dialogue on the disadvantages encountered by Black people subject to MHA assessments, and the necessity to recognise the unique institutional, racial, social and cultural nuances that impact AMHP decision-making. Additionally, the tensions and complexities of inter-agency working and limited resources that AMHPs must negotiate. I also discuss the implications of this study in relation to AMHP practice and policy contexts and this will be accompanied by corresponding recommendations. I will highlight how the findings of this study bring forth a new discussion around the role of social capital which adds to the dominant literature related to the disproportionate detention of Black people which focuses on the impact of racism and racialisation. I will then discuss the strengths and limitations of the study and conclude the chapter by sharing my plans for dissemination and suggestions for future research.

9.2 Integrated discussion

The findings chapters of this thesis analysed and described the relevant sections of the MHA legislation, embodied practices, systematic processes and textual coordination (Smith 2005, 2006) involved in the four main work phases in progressing an MHA assessment from the initial referral to post assessment requirements. There was specific emphasis on AMHPs' account of MHA assessments with Black and/or Minority Ethnic service-users detained under s.3 MHA.

Chapter 5 "Risky Business" examined the institutional policies and procedures which governed the acceptance of a referral for an MHA assessment. This emphasised the complexities and challenges associated with assessing and contextualising risk when the person being referred is from a Black or Minority Ethnic group. In trying to "build a picture" of the person to be assessed participants' consideration of historical risk was crucial in framing current risks. For Black people, the nearest relative was often a key player in terms of the proximity to the person referred and their experience of the behaviour causing concern.

Chapter 6 "Lost in Translation" moved the discussion to the MHA assessment interview where the complex interactions between AMHPs and Black service-users subject to assessment, their nearest relatives and other professionals were analysed. The impact of language and culture on understanding the individual being assessed. Collier and Thomas' (1988) cultural identity theory offered theoretical lens through which

to better apprehend understandings of values, customs and beliefs and its impact on intercultural and intracultural communication (Samovar & Porter, 2009) between AMHPs and service-users from Black ethnic groups. Wharton's (2009) concept of emotional labour provided a perspective through which to understand how participants managed adversarial tensions with BME service users and their families in accordance with institutional rules and societal expectations. The data suggests that language barriers, cultural misunderstandings, lack of service-user engagement and stereotypical assumptions about Black people impact participants' decision-making.

Chapter 7 "Is it a crime?" looked at the institutional processes involved in the decision and outcome of the MHA assessment. Participants described pressures of working with limited resources and the tensions that arise from inter-agency and multidisciplinary work - in particular, disproportionate police involvement in the MHA assessment process for Black service-users.

Chapter 8 "A cheeky look" completed the four-part narrative by unpacking the ways institutional systems and processes generate challenges for AMHPs in doing "moral work" such as critical reflection on decision-making; feedback from Black service-users on their experiences of the MHA assessment and follow-up on eventual outcomes for people compulsory detained under the MHA. This study revealed that AMHPs' expected adherence to institutional processes reflected that in some instances text-based accountability created a moral-dilemma where AMHPs felt they were breaking data protection rules specifically the GDPR by having a "cheeky look" at a service-users' electronic case file in order to follow-up on the eventual outcomes of their decision to detain a person under the MHA. On the other hand, some AMHPs' text-based accountability superseded their feelings of having a moral obligation to follow up on outcomes for services-users after a decision to detain, particularly decisions that impact Black people with the knowledge that for that group, there is longstanding disproportionate detention under the MHA.

Together, the findings chapters demonstrated that there are distinct differences between the formal, written texts outlining the role of AMHPs in sectioning processes under the MHA which I am critiquing as incomplete, with their informal, oral accounts. In analysing AMHPs oral accounts of their work this study was able to determine what is remaining 'invisible' (Pithouse, 1987) or what is being 'erased' (Diamond, 2006), rather than an observation of AMHPs interaction with Black service-users which was beyond the scope of the research. Themes from this research support findings from previous research into general experiences of detention processes under the MHA, while adding critical understanding of specific experiences of MHA assessment with Black people which will be discussed in the following sections.

9.3 Racism and racialisation of Black people

9.3.1 The notion of "risk"

When reflecting on their interactions and experiences of MHA assessments with Black people participants expressed particular concern that besides the phenomena of disproportionate detention under the MHA,

they felt Black people faced other aspects of disproportionality within the MHA assessment and detainment process. The criteria for compulsory detention under S2 and S3 MHA and the criteria for arrest under section 136 MHA involve an MHA assessment to establish among other things, whether the person being assessed poses a risk to themselves and/or others. These criteria themselves are subjective assessments on “risk” and could be influenced by racial biases held by decision makers of which AMHPs play a critical role. In their critical review of the emerging literature on the everyday experiences and practices of health care professionals and workers engaged in assessing and managing mental health risks Gale et al. (2016) and Horlick-Jones (2005) define the concept of “risk work,” which aims to make visible, working practices to assess or manage risk, in order to subject these practices to sociological critique.

Gale et al. (2016) identify three components of risk work, namely:

(a) Translating risk information into different contexts for different audiences.

The challenge within the translation process is the desire for safety and certainty within an inherently uncertain situation. Iversen (2014), argues that this process can be problematic as it requires nuance of experience in the process of converting complex professional judgments into “objective” information. Different terms have been used in the literature to describe these alternative forms of knowledge about risk in the translation process such as “broad, practical experiences” (Williams, Alderson et al. 2002); “tacit knowledge” (MacLeod & Stadnyk, 2015) and “intuition” (Warner & Gabe, 2004). Fox (2002) argues that these alternative forms of knowledge create an “epistemological uncertainty.” In terms of my findings from this study and my interviews with AMHPs similar to Sheppard 1990, O’Hare 2013, and Glover-Thomas 2011, I found translating risks to be fundamentally an ambiguous and subjective process as participants had varying opinions on exactly what constituted “risk” this was evident as it required “telling interpretative stories” (Tanenbaum, 1994:31). These different ideologies may result in different approaches to MHA assessments and decision-making which may have the unintended consequence of driving up rates of ethnic disproportionality in compulsory detentions under the MHA.

(b) Minimising risks in practice, this involves implementing strategies to minimise risks and maximise safety.

This explored the perceptions of health professionals, and the role of social, institutional, and political structures, professionals' unconscious bias and own (negative) judgments. Gale et al. (2016) argued that societal attitudes towards issues such as race, mental illness, obesity or sexuality, had a mediating effect on professionals' risk minimisation efforts. Some participants reflected on the ethical dilemma faced in carrying out their statutory duties as an agent of the state with a mandate for social control and responsibility for risk minimisation whilst also being acutely conscious of the persistent ethnic disparity in detention rates under the MHA and its structural roots.

(c) Caring in the context of risk which includes supporting people to make choices or preventing undue alarm after receiving risk information.

Findings of this study suggest that “caring” in this context poses a fundamental challenge during the MHA assessment as participants negotiated between what they considered “normal” and “risky” behaviours when assessing someone as a “risk to self and/or others.” Similarly, Williams, Alderson et al., (2002) argue that it is hard for practitioners to be definitive about what is a “real” risk. Gale et al., (2016) assert that what practitioners consider to be a risk is dependent on political, social, and ethical constructions. This is echoed by O’Hare et al. (2013, p. 200) who felt AMHPs had an “arbitrary understanding of risk” and Glover-Thomas (2011) who reported that AMHPs could not explicitly define risk, but instead viewed it as self-evident. Quirk et al. (2003) found that ASWs relied on pragmatism when applying the MHA in relation to the assessment of risk.

Importantly, findings from this research demonstrate that risk assessments are not a clear cut tick-box exercises however, as part of MHA assessment work processes AMHPs utilise an institutionally mandated pro forma to record risk assessments and decisions to compulsory detain, thereby adhering to the authority of institutional governance procedures in order to legitimise their decision-making. This is also reflective of institutionally authorised systematic risk assessment tools. The most frequently engaged scale for psychiatric dangerousness prediction is the HCR-20 and half of the relevant considerations fall within the category of historical (static) risk factors, such as the age at which violent tendencies first emerge. Although there may be logical reasons for relying on these type of risk factors, there is a significant danger that these risk assessment tools can intentionally or unintentionally enable discriminatory behaviour by the decision-maker. This is because these risk factors are revealed as options each time a risk assessment process is undertaken. This is evident in participants accounts of a recurring cycle of compulsory detention to PICU beds for Black patients based on assessment of risk, as participants indicated a previous history of being sectioned to a PICU inevitably raised the risk profile of the person being assessed both for the AMHP and S12 doctor, this is discussed in more detail within this chapter.

9.3.2 Risk work

Exploring the three components of risk work in relation to this study’s findings has highlighted important practical and conceptual tensions involved in the risk work AMHPs undertake as a fundamental part of the MHA assessment. As a concept this paints a useful picture of the institutional pressures and dynamics which bear upon AMHP decision-making, while highlighting questions regarding the practicalities of risk work – how does it actually get done? In many cases the foci of previous research have been outcomes or service-user experiences and not on AMHP work and AMHPs themselves. Next, I develop a critical discussion of the findings of this study on the everyday practices and experiences of social worker AMHPs engaged in assessing mental health risks for Black people as part of the MHA assessment process.

9.4 Multi-agency working

The different agencies involved in mental health, social work, social care, health and policing all work to differing legal frameworks. Yes, AMHPs have the MHA underpinning their practice, but policing for example, is underpinned by crime and disorder legislation. Therefore, the legal frameworks that are used and drawn upon to respond to people who pose a risk to themselves or others differ for each agency, and it is not always clear which one should take priority. Why these competing priorities are important, is that they reflect wider challenges of multi-agency responses to people in acute mental distress.

9.5 Disproportionate use of Psychiatric Intensive Care Unit (PICU) beds

Studies on clinical decision-makers and gatekeepers of health suggests that health professionals, hold negative implicit attitudes toward Black people and that there is a direct link between these attitudes and health professionals' treatment decisions. More specifically, racial biases act as pathways for health care to impose iatrogenic harms and inequitable health outcomes on Black people (Van Ryn, 2002; Maina et al. 2018; Hoffman et al., 2016; Hausmann et al., 2013; FitzGerald & Hurst, 2017). The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. According to Holroyd and Sweetman (2016, p. 2):

“Implicit associations (unconscious, uncontrollable, or arational processes) may influence our judgements resulting in bias. Implicit biases occur between a group or category attribute, such as being black, and a negative evaluation (implicit prejudice) or another category attribute, such as being violent (implicit stereotype).”

Correlational evidence indicates that biases are likely to influence diagnosis and treatment decisions and levels of care in some circumstances (FitzGerald & Hurst, 2017). The stereotypes of Black people, men especially, as being dangerous could be operating at a sub-conscious level on decision-makers during the MHA assessment process resulting in the disproportionate sectioning of Black people as well as the disproportionate use of PICU beds on Black people compulsory detained under the MHA.

Participants also shared that from their experiences of conducting MHA assessments, Black people had disproportionate police involvement in terms of use of control or restraint and conveyance to hospital. Participants also spoke about case files with flagged historical incidents which seemed to “stick” more to Black people and added to the perception that Black men posed a greater risk. Participants felt this perception of risk could be linked to greater police involvement and disproportionate use of PICU beds which are usually situated within a restricted area in mental health settings and hold a smaller bed capacity of up to 10 beds. A PICU ward also usually has a seclusion room which is utilised in case it becomes unsafe to a medical professional. Participants gave accounts of how Black service-users' previous or historical requirement of a PICU bed could add to the notion of current risk and was also a consideration by S12

doctors in their recommendations and AMHPs decision to detain under the MHA. This is because PICU beds are assigned to patients who pose a risk of violence to self or others, or of absconding, are acutely ill, and difficult to manage in an ordinary acute ward environment (Bowers et al., 2008). It is known that African Caribbean people in Britain are at significantly higher risk of schizophrenia and are more likely to be perceived as violent (NHS Digital, 2014; Morgan et al. 2005; Singh et al. 1998; Gov.uk, 2021; Pinto et al., 2008).

A review of the literature on the causes for the high incidence of schizophrenia amongst the African-Caribbean population in Britain conclude it may be due, at least in part, to a range of contributing factors namely: misdiagnosis by White British psychiatrists, unemployment, social disadvantage status, social adversity; social isolation and racism in the health and criminal justice systems (Louden, 1995; Hickling et al., 1999; Morgan et al. 2006; Kirkbride et al., 2006; Sashidharan, 1993; Pinto et al., 2008). There is a paucity of recent published epidemiological data and documented studies of the prevalence of schizophrenia and other psychiatric conditions in the English-speaking Caribbean. However, higher incidence rates of schizophrenia in African-Caribbean people in Britain is at odds with the incidence rates reported for Caribbean countries such as Trinidad (Bhugra et al., 1996); Jamaica (Hickling & Rodgers-Johnson, 1995) and Barbados (Mahy et al., 1999) this is because it has been found to be similar to the rates for the White British population. Explanations in terms of clinician bias and misdiagnoses by White British psychiatrists unfamiliar with Caribbean culture and beliefs are limited by studies showing that the difference in incidence rates persists when diagnoses are made by an ethnically matched or blinded rater (Hickling et al., 1999; Fearon et al, 2006).

In Hickling et al., (1999) study of 66 patients at the Maudsley Hospital in the UK: 24 were White ethnicity, 29 were African Caribbean ethnicity, and 13 were Black people from other countries of origin. Dr Hickling, a Black Jamaican psychiatrist, conducted a standard clinical assessment of these patients. The diagnoses of the Jamaican psychiatrist were compared to the case note diagnoses by White British psychiatrists. Of 29 African and African Caribbean patients who received a diagnosis of schizophrenia, the diagnoses of the British and Jamaican psychiatrists agreed in 16 (55 percent) and disagreed in 13 (45 percent). Agreement between the Black Jamaican psychiatrist and his White British counterpart over which patients were schizophrenic was poor. However, one component of this research remained unpublished in the UK. When the diagnoses of the 24 White patients were compared, the diagnoses of the British and Jamaican psychiatrists agreed in 18 (75 percent) and disagreed in 6 (25 percent) patients. The findings of the Hickling et al., (1999) suggested that diagnostic agreement between the Jamaican and the British psychiatrists was much more reliable when the patients were White than when they were Black. Contrastingly, Lewis et al., (1990) refuted the claim that schizophrenia was over diagnosed on the basis of ethnicity. Out of a study sample of 220 British psychiatrists 139 completed a case vignette of a psychotic illness. Findings showed no statistical difference was found between the diagnostic attitudes of foreign and British-trained graduates.

Previous research has drawn attention to the high numbers of Ethnic Minority patients within PICUs (Bowers et al., 2008; Pereira et al., 2006; Feinstein & Holloway 2002). Interestingly, Bowers et al. (2008) found that a PICU admission was positively associated with male gender and younger age, with patients from Caribbean backgrounds twice as likely to have a stay in a PICU unit, however, there were no significant differences for Black African, White and 'other' ethnic groups. Bowers et al. (2008) argue that the fact that Caribbean patients were more prevalent in PICUs than Black African patients suggests that there is a particular aspect of the Caribbean mentally ill population (rather than racist perceptions of dangerousness) that leads to their excessive numbers in PICUs. However, Bowers et al. (2008) also acknowledge that there is no conclusive evidence in their study which explains the reasons for the twofold over-representation of African Caribbean patients on PICUs.

There is concern that these disproportionately high numbers of Black Caribbean men on PICUs might be due to racially biased risk assessments linked to the notion of Black people as “big, black and dangerous” (Prins, 1993). Wilson et al. (2017), found evidence that people have consistent biased perceptions of young Black men’s size as bigger (taller, heavier, more muscular) and more physically threatening (stronger, more capable of harm) than young White men. These findings suggest that perceptions of young Black men as more dangerous than young White men may reflect stereotypes of Black men that do not seem to conform with reality. This may explain why participants felt that Black men with a previous history of requiring a PICU bed are disproportionately more likely to be, assessed as posing a greater “risk to self-and/or others.” Participants noted that risk flags/indicators used as part of the case record used to inform the MHA assessment are routinely copied and pasted from one electronic case record to the other without the context of the risk being explained. Participants explained these risk indicators are used in the electronic record in order to build a picture and assess risk as part of the MHA assessment. These risks are considered before AMHPs’ face-to-face meeting with the person being assessed. The electronic case record also includes other personal identity information such as a person’s age, gender, ethnicity and address.

Participants explained at the point of the initial risk assessment is when an AMHP considers whether resources such as a PICU bed may be required. Due to this work practice, participants expressed concerns that Black men may be liable to get “stuck” in a cycle of risk aversion by AMHPs and S.12 doctors during the MHA assessment process and automatically flagged as posing greater risk by virtue of having a previous stay on a PICU as part of their recorded case history. Wilson et al. (2017) study findings noted further concerning patterns pertinent to this research. While both White and Black participants displayed bias and overestimated the size and strength of Black men, Black participants did not perceive or label them as more dangerous or deserving of control by force. Black men with darker skin and more pronounced “Black” facial features (wide nose, large lips, etc) were subject to more distortion even though they were actually no larger than men with lighter skin and less stereotypical facial features. Monk (2015) found that darker skin tone, even within the same racial group, is associated with higher rates of mental health problems as well as greater exposure to perceived discrimination and is a significant risk factor for mental disorders, distress, depressive and anxiety symptoms and conduct problems (Williams & Mohammed,

2009; Monk, 2015). Morgan et al., (2005) examined how 42 African Caribbean patients with first episode psychosis interacted with mental health services compared with a similar group of non-Caribbean patients. Morgan et al. (2005) noted that African Caribbean patients were perceived as being significantly more violent towards practitioners and clinical staff. This perception was supported by significantly higher rates of reported violent acts or assaults against staff. Participants expressed concern about the implicit associations between African Caribbean men, violence and crime which fed into diagnosis which then informed their assessment of risk in the MHA assessment.

Bowers et al. (2008) also argued that these ethnic differences within PICUs were due to differential routes of admission by ethnicity for example, more Black Caribbean people were admitted via the criminal justice system. Unfortunately, national statistics on ethnicity and the CJS (Ministry of Justice, 2021) does not breakdown Black ethnic groups therefore there is no distinction between Black African and African-Caribbean people in the reported figures. In general, Minority Ethnic groups appear to be over-represented at many stages throughout the CJS compared with the White ethnic group. Among Minority Ethnic groups, the Black ethnic group was often the most over-represented. The greatest disparities are at the point of stop and search, custodial remands and prison population. When examining ethnic variations in pathways to acute care and compulsory detention for people experiencing a mental health crisis Black people are between 20 percent and 83 percent more likely to access treatment through a police or criminal justice route (Mind, 2020).

Lawlor et al., (2012) explored ethnic variations in compulsory detentions of 287 women from White British, White other, Black Caribbean, Black African and Black other groups admitted to an acute psychiatric inpatient ward or a women's crisis house in four London boroughs during a 12-week period. Findings found that all groups of Black patients and White other patients were significantly more likely to have been compulsorily admitted than White British patients. Immediate pathways to care differed: White other, Black African and Black other groups were less likely to have referred themselves in a crisis and more likely to have been in contact with the police. However, methodological limitations, such as very broad categorisations of ethnic group, small sample sizes and limited adjustment for potential confounding factors, have characterised much research in this area thus reasons for such differences remain poorly understood.

Evidence that links drug use by African Caribbean people to higher rates of psychosis is divided (Hamilton, 2017; Littlewood, 1988; McGovern & Cope; 1987). Two studies which examined use of PICU beds found a link between Caribbean ethnicity, cannabis use and delayed recovery from mental illness (Isaac et al, 2005; Feinstein & Holloway, 2002). However, a report by the UK Drug Policy Commission [UKDPC] (2010) showed that in general, overall drug use is proportionally lower among Minority Ethnic groups than among the White population. Cannabis is the most commonly used drug across all ethnic groups and age groups. With regard to BME people, the report states:

“BME communities may be at risk of drug use because they often live in disadvantaged and deprived areas, where drug markets thrive. Additionally, a number of Minority Ethnic groups, particularly refugees and asylum seekers, face high levels of unemployment, isolation and social exclusion. Limited opportunities can lead to frustration, boredom and anxiety increasing the likelihood of drug use” (UKDPC, 2010, p. 6).

9.6 Systemic racism?

When reflecting on the reasons for the persistent ethnic disparities in mental health outcomes and disproportionate detention rates under the MHA, of particular concern was participants concurrent awareness and acknowledgment that the ethnic disparities within the mental health system mirror wider experiences of systemic racism in society. Accordingly, systemic theories suggest that the disproportionate detention of Black people under the MHA must be considered in a wider societal context, which includes examining the impact of racialisation and racism. It can be argued that western civilisation, notably the UK, was founded on multiple systems and institutions that racialise and exploit Black people. This has resulted in the legacy effects of slavery, Imperial Colonialism and ideological ways of understanding the world. In order to deconstruct and challenge these discourses and ideas, we must critically examine the assumptions that underpin Western civilisation and hegemony.

According to Feagin (2004) systemic racism is often denied and instead conceptualised as minor, temporary or isolated examples of racism. Likewise, former UK Prime Minister, Boris Johnson set up the Commission on Race and Ethnic Disparities (CRED) in 2020 in the wake of the Black Lives Matter protests following the killing of George Floyd by a Minneapolis police officer in the US and the upsurge of concern about race issues it inspired. The CRED comprised of ten members drawn from a variety of fields spanning science, education, economics, broadcasting, medicine, and policing and, with one exception, all from ethnic minority backgrounds (CRED, 2021). CRED was tasked to look at race and ethnic disparities in education, employment, crime and policing and health. The Cabinet Office’s Race and Disparity Unit (RDU), which was set up in 2016 and has accumulated all the important data on race and ethnicity, in one database, supported the CRED. This was the first time the RDU’s dataset has been able to be used to understand the impact of ethnicity and other factors on outcomes. Unlike previous reviews which focused on particular issues such as the workplace or criminal justice, the CRED looked more widely and investigated the deeper underlying causes of key disparities. The CRED report also known as the ‘Sewell Report’ concluded that the UK is not an institutionally racist country and instead offered “a model for other white-majority countries.” (gov.uk, p. 9). The Chair of the Commission Dr Sewell said in his report:

“Put simply, we no longer see a Britain where the system is deliberately rigged against ethnic minorities. The impediments and disparities do exist, they are varied, and ironically very few of them are directly to do with racism.” (gov.uk, 2021, p.1)

While the report acknowledged “overt and outright” racism persisted and said some communities were “haunted” by historic discrimination, it downplayed the importance of systemic racism in explaining inequalities in areas such as health and crime. The report prompted scathing criticism and backlash from critics. The Commission was accused of misunderstanding the nature of racism as well as whitewashing the experiences of people of colour through denying the existence of institutionalised racism (Bhopal, 2021; Runnymede 2021).

However, this study’s findings suggest that participants indeed perceive that the persistent ethnic disproportionality in detention rates could be linked to Black people’s wider experience of institutional and systemic racism. Specifically, publications regarding COVID-19, the fire at Grenfell Tower, the Stephen Lawrence Inquiry and the Windrush Scandal have highlighted institutional racism and systemic ethnic inequalities in England (Williamson et al., 2020; Platt & Warwick, 2020; Horton, 2017; Macpherson, 1999; Home Office, 2020). Evidence on the association of ethnicity and socioeconomic status are reflected in official published data that reports widespread disparities for Black people across health, employment, housing, criminal justice and education (Care Quality Commission, 2022; Kapadia et. al, 2022; Cabinet Office, 2018).

9.7 Systemic theory

Franklin et al. (2016), Hines and Boyd-Franklin (2005) posit a specific systemic theory which describes how BME people’s historical and contemporary experiences of discrimination through multiple systems – health, criminal justice, class, education, economic, political and social constitutes distress and trauma for BME people. She theorises that systemic oppression impacts BME people’s lived experiences of which mental health is a significant product. Boyd-Franklin & Shenouda (1990) and Franklin et al. (2006) implicate wider socioeconomic, historical, cultural, political and familial systems in understanding mental health disorders. Therefore, systemic theories may explain higher rates of compulsory detention under the MHA for Black people, as a result of psychological distress caused by structural ethnic inequalities. Further, systemic theories argue that BME people’s experience of psychological distress is compounded by the lack of BME perspectives within the mental health system. According to Boyd-Franklin (1989) within psychiatry and psychology BME differences have been misdiagnosed as deficits thus resulting in disproportionate and inappropriate responses from mental health professionals such as compulsory detention under the MHA.

Systemic theory also reflects previous theories which link social, political, familial and economic contexts to sectioning in the general population (Carmichael, 2015; DuBois, 2007; Cooper, 1967; Laing & Esterson, 1964). The correlation between experiences of discrimination and mental health problems has been highlighted in previous UK research (Karlsen et al., 2005; Wallace et al., 2016). This also mirrors findings of a study by Barnett et al. (2019) which examined involuntary psychiatric detention of people from BME and migrant groups in the UK and internationally and referred to the role of societal racism. There are still

debates about whether higher rates of compulsory detention of BME people is caused by racism (Singh & Burns, 2006; McKenzie and Bhui, 2007), however there was certainly a perception from AMHPs who participated in this study, that unconscious bias plays a significant part.

9.8 Social capital and Black mental health

Social capital is commonly described as having two components: cognitive social capital: subjective factors acting to keep networks together (and measured by indicators such as feelings of trust, reciprocity, familial and social support networks, community and local engagement) and structural social capital: attachment to organisations such as churches and measured by attendance and strength of commitment. Cognitive social capital has been found to be an important predictor of mental wellbeing (Nygqvist et al., 2008; McPherson et al., 2014; Almedom, 2005). According to Scheffler et al. (2007), high levels of social capital may enhance a sense of belonging and thus increase collective wellbeing. Conversely, where social capital is low individuals may feel insecure and alienated.

The nearest relative plays an important role in the MHA assessment and has legal rights and responsibilities under the MHA such as providing additional safeguards to help ensure that the compulsory powers of the MHA are used appropriately. Information provided by the nearest relatives assist AMHPs with the decision-making process on whether or not to detain the person under section 3 MHA. However, participants indicated that in addition to the nearest relative other social capital components at the individual and ecological (community) level play a significant role when AMHPs consider the “least restrictive option” and most appropriate way for the person being assessed under the MHA to receive care and/or treatment. Thus, social capital resources such as income, employment, housing conditions, social networks, family support, community engagement and relationship/trust with health professionals emerged as key factors in determining the likelihood of someone being compulsorily detained under the MHA. The analysis shows that both cognitive and structural social capital are associated with reduced odds of compulsory detention under the MHA. Participants indicated that the majority of Black service-users they assessed under the MHA lacked both cognitive and structural social capital.

This lack of social capital was highlighted in the Race Disparity Audit (Cabinet Office, 2018) which reported that adults from a Black ethnic background reported the lowest ratings for life satisfaction. All the Black ethnic groups were also disproportionately likely to live in the most deprived neighbourhoods with low quality housing and were more likely to be poor and in persistent poverty. In terms of ecological social capital, compared to other ethnic groups, Black adults were least likely to feel that their local area is a place where people from different backgrounds get on well together (Cabinet Office, 2018). Additionally, census data which shows the types of families and other groups living in households in England and Wales by ethnicity, reports that 18.9 percent of Black households were made up of a single parent with dependent children, the highest percentage out of all ethnic groups for this type of household (gov.uk., 2019). When viewed in the context of a MHA assessment, AMHPs viewed a person’s social capital can be thought as a

significant resource to effectively support and manage their mental health and wellbeing, negating the need for compulsory detention under the MHA. Instead, social capital relies on established support networks or the ability to obtain resources to manage one's mental health safely within the community.

9.8.1 The link between social capital and compulsory detention

A significant finding of this study was that participants noted that during MHA assessments and their considerations on whether to detain an individual under the MHA, significant value was placed on the individual's social capital. Three aspects of social capital were viewed as most significant during the MHA assessment and lessened the likelihood of compulsory detention namely:

- i. Emotional support: during mental health crises, particularly those caused by stressful situations, support networks may help a person to find a solution to the problem before it escalates, reduce the perceived importance of the problem, or provide a distraction from the problem. Participants found that in some instances simply knowing they have a potential support network increased a person's sense of self efficacy and control.
- ii. Reinforcement of positive behaviours: AMHPs found that family, friends and social networks influenced whether individuals took medication as prescribed, sought early voluntary treatment when their mental health showed signs of deterioration and encouraged positive habits such as exercise and eating healthy diets.
- iii. Advocacy and service brokerage: social networks help advocate for effective access to community mental health services, housing, employment, or training services for persons who would be unable or unwilling to access these services by themselves.

Research into the social determinants of health inequalities is increasingly focusing on macro-level forces affecting individuals and communities (Alderwick et al., 2019, 2018). Bertotti et al. (2013), argue that social policy should support interventions that create and sustain social networks. Thus, if the concept of social capital is to be used as a potential explanatory framework for understanding disproportionality in detention rates of Black people under the MHA, this needs to be looked at closely. In particular, contextual indicators and refining definitions of social capital to include for example, "virtual communities" forged with the aid of electronic technology and largely reflect the changes in social interactions related to periods of mandated COVID-19 restrictions. In addition, the role of generalised trust for improving mental health outcomes of Black people, as well as ensuring access to resources and infrastructure. Close attention should be paid to disadvantaged communities such as those without propinquity (Calhoun, 2007).

Social capital is not new to public policies. However, this study has shown that social capital may be a promising heuristic for future studies examining ethnic disproportionality in detention rates under the

MHA. This may even help mental health professionals such as AMHPs and psychiatrists in designing targeted interventions and offer policy makers a paradigmatic approach to solving longstanding mental health disparities. The relationship between social capital and health, education, efficacy of government, crime and economic growth explains why social capital is attracting the interest of policy makers globally (Montgomery, 2000; Frank, 2003; Claridge, 2018). Despite all this promise, social capital is not a panacea, there is still a paucity of strong evidence supporting the hypothesis that social capital protects mental health (Whitley et al., 2005).

Social capital may be an influential factor for AMHP decision-making only at certain threshold points. This is because for those individuals or groups with virtually no social capital, even a modest increase may make a large difference in mental health outcomes. However, we must also bear in mind that increased social capital does not always equate to better outcomes. For example, White et al. (2005), argue that while one's social networks may, through positive reinforcement, encourage successful educational attainment, they can have an equally opposite effect in close knit families or communities where parents and other members have low educational attainment and aspirations. Within mental health, this can be reflected in the "circles of fear" (Keating et al., 2002, p. 24) which results from BME groups in particular African-Caribbean people's perceptions of discrimination and unequal treatment by mental health professionals. This has generated deeply entrenched mistrust of mental health services within these communities – even among those with no first-hand experience of services may act as a powerful barrier to their engagement with AMHPs and other mental health professionals (Edge & MacKian, 2010; Islam et al., 2015). This is not to argue that social capital is unimportant, but rather to acknowledge that if used by AMHPs as part of their decision-making process it must be considered in relation to a number of other resources and factors such as the historical context of longstanding systemic and structural disadvantages faced by Black people in Britain (Cabinet Office, 2018) - leading to their disengagement from mainstream mental health services, social exclusion and a deterioration in their mental health.

Having discussed the link between social capital, Black mental health and detention decisions as part of the findings of this research, in the next section the study turns to understanding how these dynamics translate into AMHP practice. I try to unpack the inherent complexities in effectively enacting the notion "bringing a social perspective to bear on their decision..." (DOH, 2015, p. 122) in AMHP policy and practice.

9.9 Enacting the social perspective in AMHP practice

Whilst the current MHA Code of Practice (DHSC, 2015) promulgates "...bringing a social perspective to bear on their decision and taking account of the least restrictive option..." (DHSC, 2015, p. 122) as a key purpose of the AMHP role, there is no accompanying guidance regarding how the social perspective should be enacted. From my understanding of the MHA and Code of Practice (DHSC, 2015, p. 122) the social perspective is intended to provide a broad context to inform AMHP detention decisions, whilst the least restrictive option is meant to explore alternatives to compulsory detention which maximise independence

within this social context to achieve safe and required treatment outcomes. Therefore, both the social perspective and least restrictive option are interdependent concepts in relation to AMHP decision-making. However, findings from this study have challenged my conceptualisation of the social perspective. Having been introduced into the MHA legislation through the 2007 amendments, neither the MHA nor the Code of Practice provide an explicit definition for the term “social perspective.” In fact, out of a total of 459 pages, the term “social perspective” is mentioned only once on page 122 paragraph 14.52 of the MHA Code of Practice in describing the role of the AMHP (DHSC, 2015). The term is also not defined or included in the codes of practice published prior to the 2008 Code of Practice. Consequently, the social perspective may be interpreted and applied inconsistently within AMHP practice (Fish, 2022; Karban et al., 2021).

The term “social perspective” is included in S18.64 of the MHA 2007 explanatory notes (legislation.gov.uk, 2007) which describe the intent behind its inclusion in the context of a move away from the prior role of the ASW to the new role of the AMHP:

*“This means that there will be a mix of professional perspectives at the point in time when a decision is being made regarding a patient's detention. This does not prevent all those involved from being employed by the NHS, but the skills and training required of AMHPs aim to ensure that they provide an independent **social perspective**.”* (legislation.gov.uk, 2007).

In my interpretation, the “mix of professional perspectives” is meant to emphasise the importance of a holistic approach to detention decisions, whilst the “social perspective” is an expression of the unique skills and competencies of the AMHP role. This is an explicit recognition that medically trained professionals do not have sole dominion over mental health. A more diverse skill set which embodies professionals with “social” oriented work knowledge and expertise is required when making a decision regarding detention (Tew, 2005, Hatfield, 2013). A key element to the provision of a ‘social perspective’ entails independent decision-making by non-medically trained professionals in efforts to ensure service-user choice and effective treatment (BASW, 2015). Furthermore, the AMHP role is carried out by a group of distinct eligible professions namely: social workers, psychiatric nurses, occupational therapists and clinical psychologists all of whom are expected to enact the social perspective albeit within the range of unique skills, knowledge, ethics and values espoused by their professional identities (Coffey & Hannigan, 2013; Knott & Bannigan, 2013). With this in mind and compounded by the absence of an explicit definition for the term within the MHA and Code of Practice it will be naive to assume that understanding and applying the concept of “social perspective” in AMHP practice is anything but complex, ambiguous and nuanced. There is therefore the risk of possible professional, cultural and individual biases slipping into the AMHP decision-making process including an adherence to medical perspectives. Stone (2019) addresses some of these concerns and found that there was little difference in the decision-making between social worker AMHPs and nurse AMHPs, this is because decisions were of an individualistic nature rather than related to professional identity.

Despite these inherent complexities, a useful framework in which to consider the concept of “social perspective” is offered by Tew et al. (2012) and Tew (2011, 2005). Specifically, his “cornerstones” give context to the application of the ‘social perspective’ in practice. This unofficial working definition of social perspective may offer a way to explore the various complexities and nuances of the concept in relation to this study. I will now summarise the various elements. Firstly, a focus on situated knowledge (Haraway, 1988) and lived experience, sought through dialogue which facilitates an exchange of ideas and opinions instead of “us” versus “them” distinctions which locate expertise and initiative in the hands of the professionals, and marginalise service-users into roles of social exclusion, passivity and potential dangerousness. Secondly, looking at the person with a holistic lens, not just their mental needs, being cognizant and sensitive to their experiences of adversity whilst also acknowledging their strengths and resources. Thirdly, an awareness of the impact of imbalances of power, both in terms of previous experiences and relationships as well as the effect of discrimination and stigma that people may experience as a result of their mental distress. Tew (2011) underscores the need to identify the opportunities for power to be used to protect, advocate or encourage joint working. Fourthly, Tew highlights a collaborative approach to recovery which he inextricably links to social capital and social inclusion, operating on both an individual and community level through social networks. Lastly, the importance of action planning is highlighted, intentionally avoiding medicalised language which refers to “care” or “treatment.” Although not intended as an official checklist for the applying a “social perspective” in practice, in the absence of explicit guidance in the MHA and Code of Practice, these cornerstones help to inform and contextualise the discussion of the data gathered from participant interviews and this study’s recommendations for future mental health policy and practice in relation to Black service-users and other marginalised groups.

9.9.1 Has the social perspective lost advocacy in policy making?

Although the “least restrictive option” and the “social perspective” appear to be interdependent concepts in the MHA, recent MHA reform proposals have excluded reference to the “social perspective” altogether, instead placing emphasis on the significance of law and policy to apply the principle of “least restrictive option” (DHSC, 2021, p. 10). The non-inclusion of the ‘social perspective’ is most obvious in latest reform proposals within the past five years such as the ‘Reforming the Mental Health Act’ (DHSC, 2021); the ‘Independent Review of the Mental Health Act’ (DHSC, 2018) and the White Paper (DHSC, 2021) and the CQC’s report ‘Monitoring the Mental Health Act in 2021-2022’ (CQC, 2022). This is a worrying development as there has been no real change resulting in the various reports, initiatives and plans for change aimed at tackling the disparities in detention rates of Minority Ethnic groups, in particular Black groups who continue to be disproportionately subject to compulsory powers under the MHA.

This is compounded by the fact that organisations such as Social Perspectives Network (SPN), formally launched in 2002 as a diverse and unique “coalition of service users/survivors, carers, policy makers, academics, students and practitioners interested in how social factors both contribute to people becoming distressed and play a crucial part in promoting people’s recovery” (SPN, 2022) cease to exist due to lack

of government funding. The SPN objectives were to share work and information looking at mental health from a social perspective; to support people to put social perspectives into practice and influence the development of mental health policy from a social perspective (SPN, 2022). The SPN was summarily defunded in 2017 by the DHSC around the same time work on the Review of the Mental Health Act (DHSC, 2018) was gaining momentum. Raising critical questions about distinct funding priorities, alas one could argue, the social perspective was de-prioritised and genuine opportunities for progress towards addressing ethnic disparities in mental health outcomes by including social models of mental health to support people to put the social perspective into practice and influence the development of mental health policy from a social perspective would have been diminished.

Despite concerns that advocacy for the social perspective is seemingly falling off the legislative and policy agenda, all is not lost! It is clear that momentum is building with regard to the social model of mental health, an important development given the abject exclusion of the social perspective from recent policy and legislative reviews. Although not always explicitly referred to as the social perspective, the social model of mental health as well as the link between mental health and various social contexts including social capital is increasingly an ever-present theme within post-pandemic and contemporary social work research. Bamford et al. (2021) explored differences in mental health and the influence of social capital among Ethnic Minority groups in Great Britain. They found more research on the definition, measurement and distribution of social capital as it applies to Ethnic Minority groups in Great Britain, and how it influences mental wellbeing is needed. Villalonga-Olives et al. (2022) systematic review of nearly 400 articles found that community and multilevel social capital interventions are key to curbing mental health symptoms among refugees. Hussenoeder (2022) introduced the concept of online social capital as the first step in this direction, and showed how it could be applied to the area of mental health. Rodela et al. (2020) found that alongside faster recovery from socioeconomic challenges, social capital interventions may strengthen the social determinants of mental health and empower communities to alleviate the psychosocial consequences of the COVID-19 pandemic. Lebenbaum et al. (2021) investigated the effect of mental health on social capital. Findings highlight the need for policy makers to implement greater prevention and treatment for poor mental health and provide greater support for individuals with poor mental health so they can build and maintain their social capital. Karban et al. (2021) highlight the complexity of AMHP practice and the diverse ways in which AMHPs attempt to apply a social perspective. Keating et al. (2019) examined what socially oriented approaches to recovery in mental health mean for African and Caribbean men, and what was felt to help to support such recovery. Findings revealed that safe spaces are required to support social recovery and are needed before men can develop relationships of equality, authenticity and trust.

9.9.2 Locating the social perspective within MHA assessments

Study participants noted that as part of the MHA assessment there was a requirement to demonstrate how the assessment outcome had been arrived at. Where compulsory detention is deemed necessary, participants were required to record whether grounds for detention were met in regard to the service-user's mental

disorder, its acuity and history, the management of risk and the availability of appropriate medical treatment. There was no specific obligation to detail what least restrictive options were considered. This finding is of particular concern in the context of findings by Wickersham et al. (2020) who used AMHPs' MHA assessment records as a primary data source of their empirical study and found 33 out of the 150 MHA assessments (22 percent) were missing or incomplete. In addition, a higher proportion of AMHP reports were missing in the "not detained" group (40 percent) when compared with the "detained" group (14 percent) (Wickersham et al., 2020). This highlights a lack of consistency and transparency which restricts the potential to measure, compare or track the availability or effectiveness of different options for treatment and the social context in which those cases were considered. Again, we see evidence of the principles of the 'social perspective' being sidelined in favour of informal or institutionalised processes that do not allow for an audit or review of precisely how the least restrictive option is determined. This may be a factor in ethnic disproportionality in rates of detention as AMHPs may not always have the capacity or time to delay an application for detention until a less restrictive option has been tested. This, along with no obligation to record which least restrictive alternatives were considered might encourage AMHPs to compulsorily detain a service user instead of trying alternatives to detention. However, most participants acknowledged that lack of resources such as under-resourced crisis teams, community teams or crisis houses also limit the accessibility to possible alternatives to detention.

9.10 Summary

The social perspective of mental health is a perspective that provides an understanding of mental health within the social contexts within which people exist and uses practice and evidence to work with communities and individuals to help prevent mental health problems and to help with their recovery. The social model recognises that prevention and recovery are best achieved in a holistic way. Social work has contributed greatly to the development of mental health services but in recent years its place and the social perspective has tended to become marginalised. This is particularly detrimental to communities at greater risk of mental health problems and compulsory powers under the MHA such Black and Minority Ethnic groups. The social perspective is crucial to MHA assessments and AMHP decision-making with Black people because it recognises that mental health issues can be influenced by systemic racism, discrimination and social inequalities. By considering the social context, interventions can address unique challenges faced by Black people, promote cultural and religious sensitivity and ensure more effective and equitable support for their mental well-being.

9.11 Implications and recommendations

My experience of presenting early findings of this research to participants suggests that social worker AMHPs are interested to think about how their work fits into broader organisational processes; how the work of others fits into what they do; how policies, texts and documents connect and coordinate practices and how people are able to participate in discourses. An important orientation of this work is to produce

new knowledge that connects people's experiences with historical and social contexts. This was achievable by using a research method which is concerned with getting under the skin of typical explanations of social happenings. Utilising a research method with a critical stance was necessary because the long-standing disproportionate detention of Black people under the MHA is a debated and historically contentious issue.

The AMHP role is a complex one. It is also unique among the tasks of social workers and other mental health professionals in that the AMHP acts as an autonomous professional rather than an agent of their employers, whether it be a local authority or an NHS Trust. This study's analysis indicated specific areas of AMHP practice where forms of social action can be initiated and informed by the ruling relations. Due to its statutory nature, the effects of the institutional work processes of informants are generalisable across many AMHP services, and the ruling relations of these processes have generalising effects. We see how AMHP work activities are connected as sequences in a work process intending to balance the rights of the service-user with their possible need for protection and treatment.

Reducing the disproportionate compulsory detention of Black people under the MHA is not the sole responsibility of AMHPs but requires comprehensive and systemic approaches and a concerted effort from all levels of society, including policymakers, mental health professionals, social workers, healthcare providers, law enforcement, and community organisations. I hope that the findings and implications of this study are taken up in advocacy efforts to promote sound policy reform. To inform this work, I highlight the following implications for AMHP policy and practice:

9.11.1 Prioritise the principle of “social perspective” in legislative and policy reforms and consensus on how this will translate into AMHP practice

The AMHP's statutorily defined role is meant to be guided by principles of the “social perspective.” This has its ethical foundations in decisions and/or interventions which maximise individual choice and the selection of the least restrictive option for safe and lawful treatment, whilst protecting service-users from unnecessary and unlawful detention (DHSC, 2015). In order to enact the principles of the social perspective AMHP decision-making should be informed by a range of social theories. By considering these theories AMHPs can gain insights into how social factors impact a person's mental health. However, the social perspective (DHSC, 2015) remains a neglected priority, low on the agenda of policy decisions and law reforms thus reducing its safeguarding function to the service-user. There remains a considerable need to address the de-prioritisation and defunding of initiatives which promote social perspectives within mental health services including AMHP practice, perhaps even more so in the wake of the COVID-19 pandemic. Paradoxically, whilst reference of the social perspective has been neglected in recent MHA law and policy reforms, there is a growing body of contemporary academic research and professional literature which focus on the interpretation and implementation of the social perspective as it relates to the rights of individuals subject to compulsory detention under the MHA (Fish, 2022; 2022, Karban et al., 2021; Simpson, 2020; Abbott, 2018). Explicit guidance on how the principle of “social perspective” promulgated in the MHA

and MHA Code of Practice (DHSC, 2015) should be interpreted and implemented in AMHP practice is urgently required. This includes consensus on how the social perspective should translate into actual AMHP decision-making processes and how this will align with other interdependent statutory objectives such as applying as the least restrictive option, these changes may lead to outcomes more consistent with legislative reform.

9.11.2 Policy initiatives that recognise and invest in the different forms of social capital deployed by Black people in the UK

As discussed in previous chapters, the inextricable link between mental health, socioeconomic mobility and access to social capital is well documented in the literature. Consideration of social capital has yet to occupy a prominent role in the processes that lead to involuntary detention rates amongst Black people. AMHPs indicated that a key factor in their detention decision-making was a person's access to social capital which allowed them to have the support systems to stay well in the community and not requiring compulsion. Therefore, holistic approaches to mental health that recognise Black service-users' psychosocial health as a product of their interaction with their environment should be prioritised over biomedical approaches. Recognition of the various forms of social capital preferred and deployed by Black people in the UK could help prevent and/or decrease the incidence of poor mental health in these communities thereby reducing involuntary detentions under the MHA. As part of implementing the "social perspective" an ethnic-conscious framework for social capital can be developed that is inclusive of and co-produced by members of the Black community, including social workers, health professionals, people with lived experience, service-users, academics and advocacy groups. This is critical to the implementation of solutions that achieve socioeconomic mobility via pathways that include the access to social capital, using specific ethnic identifiers to narrow mental health inequality gaps. This will require initiatives and measures, that are not traditionally the remit of AMHP work but may be seen as included in social work support at the community level. These will include actions which focus on education, income generation, legal support, vocational training and the reduction of stigma associated with mental health in family and community systems. Support for the recognition of social, cultural, civil, political and economic, social, rights of Black service-users may be thought of as radical shift in AMHP practice as it seeks to empower individuals to participate in creating self-advocacy and social change.

Participants have attributed ethnic disparities in detention rates due to limited bed availability which have resulted in persons detained under the MHA often being detained in hospitals a long distance away from their local communities to what in most cases is the only available bed in the country. This raises particular disadvantages for people from racialised communities, as Black service-users who are detained and conveyed to out of area psychiatric hospitals are often cut-off from their local communities and further isolated which in some instances leads to a worsening of their mental distress which may hamper recovery. As part of its consideration of the social perspective and the least restrictive alternative, MHA assessment processes should record access to actual systems and structural forms of social capital that individuals can

access, as well as features of organisations that make it possible to achieve some coordinated or purposive action which aids and maintains recovery and strengthen social ties. These systems include racialised communities' access and proximity to their local community, social networks, advocacy groups, neighbourhood, relatives, friends, support networks, culturally specific food and amenities, places of worship, public transportation, public services and other sources of social capital which are important in reducing recovery times and preventing relapses of poor mental health. Additionally, families commuting long distances to visit detained relatives face socio-economic costs as longer commutes translate to lost income as a result of days taken off from work and further reductions in disposable income for additional expenses such as hotel stays, petrol, car maintenance, public transport tickets and childcare arrangements. This re-iterates the common thread in previous chapters that access to social capital and cohesion is the premise that there is value in social networks and that the norms that exist within the networks of racialised communities produce expectations of actions, such as cooperation or reciprocity exchanges, which advance individual and collective goals as well as cognitive and attitudinal aspects such as perceptions of trust and feelings of belongingness. For Black service-users social cohesion and access to these networks may be crucial in aiding recovery from involuntary hospitalisation, the prevention of re-detention due to deterioration of low-level mental distress and reduce the need for involuntary detention within these communities.

Three areas of policy will benefit from an ethnic-conscious framework for social capital aimed at helping people from Black ethnic groups to shape mental health policies and programs ensuring their voices are heard and their needs are addressed namely: promoting community cohesion and development, early intervention for populations at risk of social exclusion and supporting key phases in life-course transitions. These are all areas where the deployment of resources through social relationships can have a significant impact. Policy makers will also have to consider the negative effects of social capital as discussed earlier in this thesis.

This reorientation of policy is required in order to provide cross-cutting holistic supports to members of racialised communities which includes people from Black ethnic groups. However, this policy approach necessitates a far more substantial outlay of resources and thus may prove difficult for policy makers and commissioners to conceive. The converse is also true in that an ethnic-conscious framework for social capital will incorporate mechanisms for social cohesion and upliftment for the targeted ethnic group, in this case Black communities in a way that is holistic instead of bureaucratically burdensome and fragmented. Furthermore, when compared to the cost of the numerous policy initiatives that have attempted to redress the issue of ethnic disproportionality in detention rates with no desired outcomes, these investments in community and person-centred approaches may very well be more cost-effective. This emphasises the notion that Black mental health is intrinsically linked to numerous other factors at the individual and at community levels. Therefore, ethnically framed policies and interventions targeted at Black people are therefore concerned with recognising and promoting these linkages as matters of social justice.

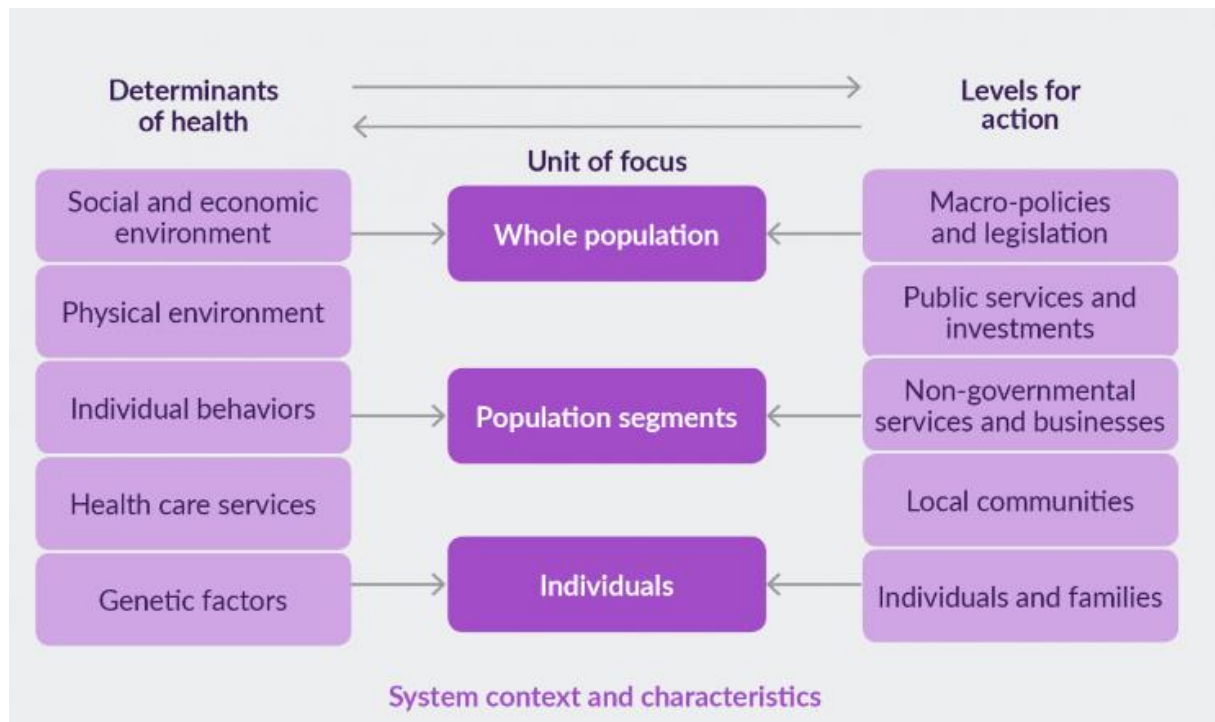


Figure 11. A framework for designing policy strategies and interventions to improve population mental health

Source: Siegel et al., 2016

The starting point for any policy strategy or targeted interventions aimed at preventing poor mental health and reducing compulsion under the MHA for people from Black ethnic groups must involve gaining a detailed understanding of the mental health needs of that population, the problem being addressed – disproportionate involuntary detention under the MHA and recognising the contribution of the wider determinants of mental health to outcomes. I propose a framework (Figure 11) introduced by Siegel et al. (2016) which illustrates the development of strategies aimed at reducing poor mental health and the need for compulsion. Although the framework was originally formulated to focus on population health it easily adapted as a framework for mental health. The three broad areas for policy makers to consider when developing a mental health strategy targeted at populations from Black ethnic groups are: the impact of the multiple determinants of mental health; the unit focus for interventions and policies and the various levels for action that are required. At each level different resources and approaches can be deployed to improve the mental health of Black populations. Siegel et al. (2016) framework is based on a holistic approach that considers various levels of influence on mental health outcomes. This framework emphasises the importance of addressing mental health issues at multiple levels simultaneously to achieve comprehensive and effective interventions. Siegel's framework typically includes the following components.

Individual Level Interventions:

These interventions focus on improving mental health at the individual level. This can include providing access to mental health services such as counselling, therapy, or psychiatric treatment. It also involves promoting mental health literacy and self-care practices among individuals.

Interpersonal Level Interventions:

This level focuses on improving mental health within interpersonal relationships and social networks. Interventions may include family therapy, couples counselling, or support groups. The goal is to enhance social support and strengthen relationships to promote mental well-being.

Community Level Interventions:

Community-level interventions target mental health within neighbourhoods, schools, workplaces, and other community settings. These may involve implementing mental health awareness campaigns, creating supportive environments, and establishing community resources such as mental health clinics or crisis hotlines.

Societal Level Interventions:

At the societal level, interventions aim to address broader social determinants of mental health. This includes policies and programmes related to education, employment, housing, and social welfare. Advocacy efforts to reduce stigma around mental illness and promote social inclusion also fall under this category.

Integrated Approach:

Siegel's framework emphasises the importance of integrating interventions across these different levels. Comprehensive interventions that target multiple levels simultaneously are more likely to be effective in improving population mental health outcomes.

Evidence-Based Practices:

Implementing evidence-based practices is a key aspect of Siegel's framework. Interventions should be informed by scientific research and evaluation to ensure their effectiveness and impact on mental health outcomes. By addressing mental health challenges through a multi-level framework that considers individual, interpersonal, community, and societal factors, Siegel's approach advocates for a comprehensive and holistic approach to improving population mental health. This framework acknowledges the complex interactions between various levels of influence and emphasises the need for coordinated efforts across different sectors to achieve meaningful and sustainable improvements in mental health outcomes at the population level.

9.11.3 Can Siegel's framework be adapted to enhance mental health in Black communities?

Siegel et al. (2016) framework for interventions aimed at enhancing population mental health may be effectively adapted to create policies and which are specifically targeted for Black and other minoritised communities by customising interventions to address specific cultural, social, and systemic factors that impact mental health within these communities. This may be achieved through:

Individual Level Interventions:

- The delivery of culturally competent mental health services that are accessible and responsive to the needs of Black individuals. This may involve training AMHPs and other mental health professionals to understand and address cultural nuances in assessment and treatment.
- Promoting mental health literacy and self-care practices within Black communities, acknowledging unique stressors and coping mechanisms prevalent within these communities.

Interpersonal Level Interventions:

- Providing family therapy and support groups tailored specifically for Black families and communities.
- Facilitating the formation of social support networks that celebrate cultural identity and resilience, thereby reducing social isolation and promoting mental well-being.

Community Level Interventions:

- Conducting mental health awareness campaigns and community workshops designed to address stigma and encourage help-seeking behaviours within Black communities.
- Establishing culturally relevant community resources, such as Black-led mental health clinics or support centres.

Societal Level Interventions:

- Advocating for policies that tackle social determinants of mental health, such as ensuring equitable access to education, employment opportunities, and housing.
- Challenging systemic racism and discrimination within institutions to create inclusive environments that support mental health and well-being for Black individuals.

Integrated Approach:

- Integrating interventions across all levels to create a comprehensive approach that recognises and addresses the intersectional experiences of race, culture, and mental health within Black communities.
- Fostering collaborations between mental health providers, community organisations, and policymakers to implement holistic strategies.

Evidence-Based Practices:

- Ensuring that interventions are evidence-based and culturally validated through research and evaluation specific to Black communities in Britain.
- Regularly assessing the effectiveness and impact of interventions to adapt and refine approaches based on community feedback and outcomes.

9.11.4 Critical reflection of Siegel's framework to improve population mental health

By applying Siegel's framework through a culturally competent lens, interventions can be tailored to meet the unique needs and challenges faced by Black communities in Britain. This approach recognises the importance of cultural identity, social context, and systemic factors in shaping mental health outcomes, aiming to reduce disparities and promote equitable access to mental health support and resources.

Reflecting critically on Siegel's framework for interventions aimed at enhancing population mental health reveals both its strengths and limitations in addressing the multifaceted nature of mental health at a population level. The framework's holistic approach, integrating interventions across individual, interpersonal, community, and societal levels, demonstrates a nuanced understanding of the various factors influencing mental well-being. This comprehensive view is essential for developing effective strategies that can have a meaningful impact on population mental health outcomes.

However, challenges arise in the implementation and adaptation of this framework, particularly in addressing deep-seated structural determinants of mental health disparities, such as systemic racism, socioeconomic inequalities, and cultural barriers. While the framework acknowledges these societal influences, it may not provide explicit guidance on how to effect meaningful change at these levels, which often require broader policy interventions and systemic reforms beyond traditional mental health approaches.

Furthermore, ensuring cultural sensitivity and community engagement in interventions is paramount for their effectiveness and relevance. Adapting interventions to diverse cultural contexts requires genuine collaboration with local communities and a nuanced understanding of their unique needs and perspectives. A one-size-fits-all approach risks overlooking important cultural considerations and may hinder engagement with mental health services among diverse populations.

Moving forward, critical considerations such as intersectionality, community engagement, equity, and social justice should be central in applying Siegel's framework effectively. Interventions must address the intersectional factors influencing mental health disparities, engage communities meaningfully in the development and implementation of interventions, and strive towards equitable outcomes that address underlying inequalities.

In conclusion, while Siegel's framework provides a valuable foundation for enhancing population mental health which includes Black mental health, critical reflection and adaptation are essential to overcome its limitations and ensure interventions are responsive to the complex and evolving challenges faced by diverse communities. Flexibility, collaboration, and continuous evaluation are imperative to developing effective and sustainable interventions that promote positive mental health outcomes for all individuals within a population.

9.11.5 A consistent approach to AMHPs recording evidence of their considerations of “least restrictive alternatives” in MHA assessment reports

There is limited and somewhat dubious data regarding AMHPs' obligation to record what least restrictive alternatives were tested or considered as part of decision-making during the MHA assessment. This limits the opportunity to accurately capture or compare which alternatives to detention were supported, leaving open the questions around the availability, effectiveness or efficacy of different options for treatment and the social context in which those alternatives were considered. A consistent approach to recording alternatives to detention which include the details of alternatives to the assessment outcome, such as home treatment interventions, increased domiciliary care, respite care or additional informal/family support is required. The AMHP should also include as part of decision-making what conversations have taken place regarding any alternative options and why these were accepted or rejected, to include any services that were not available at the time of assessment. This information is crucial for statistical and quality assurance purposes which is especially important for Black service users who are more likely than any other group to be subjected to compulsory detention. Informants reported that the only requirement on reporting on the adoption of the least restrictive option is a Yes/No recording. If this is the case, clear and cogent reasons should be available throughout the rest of the assessment report as to why a less restrictive option was/was not adopted.

9.11.6 Better resourced alternatives to compulsory detention

The disproportionate compulsory detention of Black service-users may be reduced through better discharge planning, greater bed availability, and either longer admissions, or earlier admissions (thereby avoiding deterioration in the community and the need for long admissions); least restrictive alternatives to admission such as day hospitals and crisis houses would also be potentially beneficial. Informants suggested the lack of availability of both voluntary and involuntary inpatient psychiatric hospital beds may in fact reduce detentions by increasing the pressure on AMHPs not to detain. However, others felt that bed scarcity might hinder detention minimisation, for example, by encouraging disproportionate use of PICU beds when detaining Black service users with a previous history of requiring admission to the PICU, because of the increasing the pressure to detain when beds do become available. Additionally, better resourced and more robust community services may help to reduce detentions. Participants suggested that this could comprise earlier detection and intervention, more care coordinator supervision and clearer crisis and recovery planning. This echoes findings of a mixed method study by Bonnet and Moran (2020) which focused on AMHPs' opinions regarding the reasons for the increase in detentions and potential solutions. AMHPs indicated that the demand for mental health services far exceeded the available supply, leading to more individuals being detained in hospitals due to insufficient resources. The AMHPs argued for greater investment in preventative mental health services and 'low intensity' support to mitigate the impact of social risk factors on mental health. They stressed the need for enhanced crisis services, including non-medical alternatives to hospitalisation. According to AMHPs, such investments would be more effective than legal reforms in achieving better outcomes for mental health service users. The study highlighted the importance of addressing both ends of the mental health service spectrum to alleviate the current crisis in mental health care.

9.11.5 Reduce the risk of re-traumatisation

To reduce the risk of re-traumatisation in individuals from Black and Ethnic Minority groups suffering from acute mental illness, it is crucial to implement a sensitive approach. This involves changes in both AMHP practice, clinical practice and the broader mental health service system.

Providing ongoing trauma-informed training for all mental health professionals, including AMHPs and psychiatrists, is essential. This training should cover recognising signs of trauma for people from racialised communities, understanding its impacts, and using strategies to minimise re-traumatisation during MHA assessments and treatment. MHA assessment settings should be safe and non-threatening in order to reduce coercive measures that may cause distress or trigger re-traumatisation. For example, a study by Turner et al. (2021) found that embedding mental health nurses in district police stations across West Yorkshire led to more informed and effective responses to individuals in mental distress who are subject to 999 calls. By reviewing police logs and engaging in discussions with officers, mental health nurses have ensured that the most appropriate professionals, such as mental health or social work support, respond to these calls, thereby

reducing inappropriate police interventions. This approach has yielded several benefits, including more efficient use of police resources, a reduced burden on health services - particularly Accident and Emergency departments - and enhanced awareness and understanding of mental health issues among police officers, which positively influences their interactions with the public.

Encouraging the involvement of social networks in the care process, where appropriate, can provide critical emotional stability and reduce stress. Additionally, promoting integrated care that combines mental health services with social, housing, and employment support addresses broader social determinants of health, alleviating stressors that contribute to mental health crises.

Implementing robust feedback mechanisms to gather input from service users about their experiences of MHA assessments can inform service improvements and ensure AMHP practice remains person-centred and trauma-informed.

9.12 Possibilities for the future

9.12.1 Future Research

There are several aspects of this topic that were not covered because they were beyond the scope of this study. However, future researchers may be in a better position to explore these areas after reviewing findings and critical analysis of this study. For example, this study may have benefitted from focusing on AMHPs from other disciplines such as nurses, occupational therapists or clinical psychologists.

There may also be value in using additional methods that facilitate data collection such as case studies that capture the experiences or perspectives of other people involved in the MHA assessment such as S12 doctors; Black service-users; nearest relatives; police officers; conveyance staff; non-clinical staff and commissioners. This could serve as an additional source of important information about AMHP decision-making and interdisciplinary working. The use of focus groups and observational interviews drawing on different epistemic and ontological assumptions may also be useful in highlighting the nuances of experiences and perspectives held by different people, systems and institutions.

Findings presented in this thesis indicate the need for ongoing research in relation to the disproportionate detention of Black people under the MHA. More context specific empirical evidence which expands the conceptualisations of the “social perspective” and its impact on the mental health and detention rates specifically for groups and communities who face longstanding structural and systemic disadvantage is required. However, in order to achieve this, explicit measures of social capital will need to be integrated into relevant departmental research (in policy areas most likely to benefit from a social capital perspective). A number of practical and proven measurement tools that can be applied to a variety of research instruments – from thematic longitudinal surveys to exploratory case studies – for capturing and tracking the presence

and manifestations of social capital in diverse life circumstances and local contexts. Such work would also be useful for understanding contributors to admission and re-admission to hospital. Additionally, ongoing research to understand the impacts of trauma on the mental health of Black people and effective interventions to prevent re-traumatisation should guide continuous improvement efforts.

9.12.2 Future practice

A number of suggestions for future practice have been outlined in the implications section of this study. It is crucial that standardised processes and procedures are implemented with respect to recording the least restrictive alternatives considered in decisions to compulsory detain an individual under the MHA. It is important that there is scope to evaluate the efficacy of different alternatives to detention. This must also include scope to examine mental health outcomes along with demographic data such as race /ethnicity as well as experiences of social disadvantage. This may help AMHPs and other mental health professionals be more responsive to the specific needs of Black service-users and give them opportunities to identify the socioeconomic determinants that may impact upon service-users' mental health and their outcomes.

Participants have lamented the fact that the process of completing an MHA assessment does not allow for a follow-up or feedback from service-users and/or their relatives after a decision has been made. This is also true for reviewing the case notes as GDPR and confidentiality rules mean that AMHPs resort to having a “cheeky look” at a case file in order to learn the eventual outcome of a case. In future the MHA assessment process could include a mechanism whereby AMHPs have a 30-day timeframe in which to review case notes of individuals they assessed for the purpose of supervision and reflective practice.

9.12.3 Dissemination

At the outset of this research, one of my aims was to encourage conversations about addressing the longstanding ethnic disparities in compulsory detentions under the MHA. Therefore, it is important that the findings from this study are accessible to as many people as possible. With the support of my research supervisors, I intend to publish the findings in a peer-reviewed journal. I hope to summarise my findings in poster and electronic formats, so that they can be presented and shared across several professional networks, such as the AMHP research group and the British Association of Social Workers. Impact activities will be evaluated bi-annually using web-based analytics of citations and download indices.

I intend to share the research findings with heads of AMHP services, mental health professionals, mental health networks and academics. This will be done through research participants, social media platforms and academic research websites and conferences. Feedback will be used to co-develop future engagement activities and expand interaction to include stakeholders within the Department of Health and Social Care. Policymakers will benefit from new knowledge on practitioner-led perspectives to address inequalities, which may lead to more effective policy implementation.

I have also spoken with the AMHPs from the two local authorities who participated in this study about arranging a follow up meeting where I will share with them the findings from the research, and also offer them an opportunity to reflect with each other and discuss their experiences of being part of this project. I intend to do this as a continuous professional development activity with participants which is an important requirement of registration as a social worker and demonstrates Social Work England's professional standards (Social Work England, 2019).

9.13 Limitations and challenges of this study

9.13.1 Impact of COVID-19 pandemic

The name of the method adopted for this research bears two words - institutional ethnography. It is therefore expected that the conduct of fieldwork drawing from this method is (or should be) equally divided into activities which discover how institutions function by gathering ethnographic detail about the material happenings in the work conducted by informants. Reflecting on the motivation for research drawing on the IE mode of inquiry, G. Smith (1990, p. 633) describes it as exploring the "concrete, sensuous world of people's actual practices and activities." Bisailon (2012 p. 184) talks about IE giving opportunities to "return to the nagging hunches about people's experiences" in researching the problematic.

Like many qualitative researchers, I had to adapt my fieldwork in light of the specific challenges posed by the COVID-19 pandemic. The data collection phase of this study which included face-to-face interviews and observational visits with AMHPs involved in the coordination of MHA assessments was due to start at a time when COVID-19 related restrictions and social distancing rules were mandated nationally. The COVID-19 pandemic compelled me to consider a range of methodological factors, including accessibility to technology. I had to adapt my data collection strategies to ensure I kept myself and the participants safe. I collected data remotely by utilising video conferencing platforms such as Zoom, which allowed the virtual hosting of research interviews online, consequently the observational element of my data collection was removed. Janet Salmons' E-Research framework and webinar: 'When the field is online' was particularly useful in providing a guide for the core considerations to make when conducting research online (Salmons, 2016).

Transitioning from face-to-face to online data collection strategies posed a challenge as I had initially set out to observe and interview participants in their "real-world-settings." Due to national mandates, which required people to stay at home, except for very limited purposes (gov.uk, 2020) some methodological instruments such as in-person observational work were not possible.

9.13.2 Absence of observational work

For projects that use IE, much value is added through observational work. This is because the researcher learns about people and their institutional settings in ways that interviews are unable to provide. The

discoveries made by Diamond (1992) who utilised IE to produce a compelling narrative that reveals the organisation and lineaments of work inside nursing homes in the United States, incited me to find ways to spend time with informants despite the nationally mandated restrictions on in-person gatherings. My immersion in the fieldwork surroundings was limited to a virtual space with participants. Notwithstanding my inability to conduct in-person observational work due to the COVID-19 pandemic, I learned from Diamond's (1992) exemplar and gleaned useful tips on how to pay careful institutional ethnographic attention when I found myself unable to visit and observe informants in their milieus. During on-line research interviews when I asked informants about their work, how it was organised and why they undertook it, I heeded Diamond's advice to capture rich descriptive details about informants' activities which embodied their work and experiences. This enabled me to transcend the virtual interview setting and make connections between informants' personal, social, cultural and political worlds (Mykhalovskiy et al., 2008, p. 195). However, I acknowledge the absence of observational work in an IE led to several limitations in the research namely:

- i. Limited contextual understanding: Observational work provides valuable context and insights into the everyday practices and interactions within the institution. Without it, researchers may miss important nuances and details that can impact their understanding of the institution's functioning.
- ii. Inability to capture real-time dynamics: Observational work allows researchers to capture real-time dynamics and behaviours that may not be fully revealed through interviews or document analysis alone. This lack of real-time data can limit the depth of analysis and the ability to identify patterns and trends as they unfold.
- iii. Potential bias in interviews and documents: Relying solely on interviews and documents may introduce biases, as informants may selectively share information or documents may not fully represent the actual practices within the institution. Observations can help validate or challenge the data obtained through other methods.
- iv. Missed non-verbal cues and interactions: Observational work enables researchers to observe non-verbal cues, body language, and interactions that contribute to the institution's culture and power dynamics. Neglecting this aspect can lead to an incomplete understanding of the institution's complexities.
- v. Difficulty in assessing the ethnographer's/researcher's influence: Observational work can also help researchers become more aware of their own influence on the study context and the participants. Without it, researchers may have a harder time understanding their impact and potential biases during data collection.

- vi. Inadequate validation of findings: Observational data can be essential in cross-validating information obtained from other sources. Lack of observational data may undermine the credibility and reliability of the research findings.
- vii. Challenges in triangulation: Triangulation, which involves using multiple sources of data to corroborate findings, becomes more challenging without observational work. This can lead to a weaker overall research design.

Incorporating observational work alongside other methods in IE allows researchers to gain a comprehensive and nuanced understanding of institutional practices, power relations, and social processes, enhancing the rigor and richness of the study. Despite the limitations faced with conducting fieldwork during an unprecedented worldwide event such as the COVID-19 pandemic, my use of virtual interviews allowed me to understand, dissect, report on and critique the institutional contexts of the work of my standpoint informants.

There are, however, limitations to face-to-face interviews and observational work. Denscombe (2003) argues that people respond differently depending on how they perceive the interviewer, this is referred to as “interviewer effect,” specifically, “the sex, age and ethnic origins of the interviewer have a bearing on the amount of information people are willing to divulge and their honesty about what they reveal” (p. 169).

9.13.3 Social worker AMHPs as standpoint informants

I acknowledge that by capturing only the perspectives of social worker AMHPs, the wider picture of long-standing ethnic disparities in compulsory detention rates under the MHA is somewhat narrowed. Despite social worker AMHPs making up 94 percent of the AMHP workforce (Skills for Care, 2022), including AMHPs from other disciplines such as nurses (5 percent of AMHP workforce) and occupational therapists and psychologists (collectively one percent of AMHP workforce), may have enabled me to capture and gain a richer understanding of how disproportionality is conceptualised within the wider mental health system as well as multidisciplinary perspectives of how MHA assessments are coordinated. It may have also been a good opportunity to get a sense of how other disciplines have attempted to redress these disparities, why disproportionality persists and ways to improve mental health outcomes for Black service users.

9.13.4 Limitations of the study

The credibility of qualitative research is contingent upon its trustworthiness and rigour. As detailed in Chapter Three, I employed various strategies to enhance the credibility of my findings, including triangulation, member checking, prolonged engagement, journaling, and maintaining a clear audit trail to ensure transparency and confirmability in linking participant quotes to themes and implications. Nonetheless, this study has several limitations that warrant attention: 1) small sample size and sampling

strategy; 2) reliance on memory recall of events occurring up to 20 years prior and selective memory processes; 3) lack of collateral verification; 4) absence of text analysis despite utilising IE.

The sample size of 31 participants, while relatively small, falls within the acceptable range for exploratory qualitative research, where sample sizes are often small, sometimes even in single digits (Vasileiou et al., 2018). However, the sampling and recruitment strategy poses limitations. The recruitment process relied on email invitations, which means I had no control over to whom the emails were forwarded. Using purposive sampling, initial emails were sent to AMHPs in two local authorities based on contact information obtained through my professional networks. The reliance on email, rather than postal mail, may have affected the number of AMHPs who read the invitation, potentially influenced by their email volume on any given day. Consequently, many potential participants who met the criteria may not have received notification of the study. Additionally, given the sensitive nature of recalling professional experiences with Black and/or Ethnic Minority service-users, some potential participants may have chosen not to respond, further influencing the findings.

The data collected from participants also has limitations. Participants were asked to recall events that occurred between one and 20 years prior, introducing the possibility of selective memory processes. For instance, AMHP 16 noted a tendency to remember service-users who engaged positively with the MHA assessment process, while AMHP 9 mentioned a stronger recollection of negative interactions:

"I still remember the people who I felt engaged with the process and I supported, but there were others where I just may not recall." (AMHP 16)

"Some interactions with service-users really stick with you, especially the negative ones, you don't really forget those." (AMHP 9)

Participants were also asked to recall their experiences with service-users they perceived as being from Black or Minority Ethnic groups. It was beyond the scope of this research to corroborate these perceptions. However, as practising social worker AMHPs, their recollections are likely more discerning than those of lay persons, providing a valuable basis for professional reflexivity and awareness.

Another limitation is the lack of text analysis despite employing IE as the research methodology. This was due to the nature of the participants' reflections, which focused on actual experiences with minimal reference to texts. Future research should consider incorporating text analysis, particularly of participants' case notes, to augment the narratives provided.

Finally, the findings are not intended to be generalisable to all social worker AMHPs with experience of MHA assessments involving people from Black and/or Ethnic Minority groups. The study aims to explore the experiences of the 31 participants. Furthermore, as participants were not asked about specific themes,

the prevalence of emergent themes (for example, 95% reported having a 'cheeky look' at the electronic case file after ending contact with a service-user) does not reflect their potential prevalence if those themes had been explicitly addressed.

Chapter 10. Reflections and Conclusion

10.1 Reflexive review

According to Lazard and McAvoy (2020), reflexivity in research has become more widely expected as an essential part of any qualitative research endeavour. With regard to social work research, reflexivity is viewed as the hallmark of conducting ethical, qualitative research (Probst & Berenson, 2014) and is described by Finlay (2002, p. 209) as an “explicit self-aware meta-analysis.” Reflexivity questions relations of power and ways in which knowledge about service users is generated in order to understand the researcher-participant dynamic that influences knowledge production (Sheppard et al., 2000; Parton & O’Byrne, 2000).

I have utilised the concept of reflexivity throughout this study and will now present a reflexive review that examines issues from my perspective as a Black researcher conducting ethnically focussed qualitative research. I reflect on my own position in the research process and the effect I had on the findings as well as the effect the research had on me.

May (2011) asserts that qualitative research is based on a complex relationship between researcher and subject. This requires researchers to examine the effects that their own social identity and life experiences might have on the study. To achieve this, researchers must constantly place themselves within the research. Jordan et al. (2001), have suggested that as a Black professional, my race or ethnicity likely influenced me to initiate discussion and research on race and cultural issues, and to advocate on behalf of Black communities. These views were of central importance to my approach and understanding of my identity as the researcher in this study. From my personal perspective, several aspects of my identity simultaneously support and challenge my work as a social worker, academic and as a Black woman. I am “placed” by other professionals and academics as being female, Black, African-Caribbean ethnicity, social worker, a first-generation immigrant and a first-generation academic.

10.1.1 My insider/outsider status

This “placing” of the researcher is of particular importance in research involving BME groups as there is a need to contextualise and have a deeper understanding of the history of research examining Black communities. Studies with a race and ethnicity component have historically been conducted from a White male perspective which reflects the dominant culture in the developed world (Hooks, 1992). As a result, research into BME communities has historically been framed as researching the “other” (Troyna, 1995). Researchers conducting research about Black communities are therefore encouraged to explicitly identify their inherent biases to ensure rigour. As a Black researcher this creates a paradoxical situation and made me question my identity – Am I an insider or outsider? According to Berger (2015) the “outsider” is the

best position as it involves the separation of researchers from the subject of the research. Berger (2015) argues that emotion and reason must be separated as it impacts rigour and validity of a study.

10.1.2 Emotional labour and resilience

In terms of data collection and analysis, I saw both advantages and disadvantages of my insider outsider status. However, it is difficult to say to what extent these identities have impacted on how I interacted with the participants, my analysis, or on how the study was written up. On the whole, my own identity as a Black, female, social worker might be viewed as advantageous and ideally placed to conduct race-sensitive research. It seemed to ease any potential problems concerning access to participants who were mostly White British, female and were all registered practising social workers and AMHPs.

Participants especially those with BME identities shared that they felt validated, safer and more comfortable speaking with me because I am Black. They acknowledged this feeling was likely underpinned by an assumption that we share a professional identity and understandings as social workers. For BME participants, trust and rapport was established through an understanding of common lived experiences of discrimination and inequality in relation to the research topic. This in turn seemed to enable all participants to be more open and less guarded in the interviews. However, at the participant recruitment stage there were occasions where I had to reassure potential BME participants that they would not be identified in the research output. In those scenarios I felt that my “insider” status could have been a disadvantage as there seemed to be suspicion as to my motives as a researcher. According to Serrant-Green (2002) with regard to research in areas of race and the experiences of discrimination, inequality, disadvantage and racism, when the researcher is perceived as being a member of the disadvantaged group, some might question the motives of other members of the disadvantaged group involving themselves in the discussion of an emotive and sensitive subject for information gathering or educational purposes only.

Conceptualising, developing, executing and writing up this research project has definitely been one of the most challenging things I have ever done in my life. I underestimated how difficult I would find examining relevant literature and mental health statistics pertaining to the involuntary detention of Black people which in some instances led to inquiries into the deaths of Black men whilst involuntarily detained in a psychiatric hospital. I found myself reflecting on some difficult questions, namely “am I working within structures and systems that are potentially harmful to people that look like me?” I did not truly appreciate the emotional labour (Wharton, 2009) involved in listening to accounts from AMHPs who had faced challenging situations while working with Black service-users. Collins (2000) uses the term “matrix of domination” to emphasise that one’s position in society is made up of multiple connecting standpoints rather than just one standpoint and asserts:

“Depending on the context, an individual may be an oppressor, a member of an oppressed group, or simultaneously oppressor and oppressed. Each individual derives varying amounts of penalty and privilege from the multiple systems of oppression which frame everyone’s lives.” (Collins, 2000, p. 226)

In addition, carrying out this project during the COVID-19 pandemic and national lockdown meant that for various reasons I never really found a person with whom, or a space outside of my monthly PhD supervision meetings where I could unpack these thoughts and feelings. I often felt isolated during this project and at times questioned whether the experience would take a toll on my emotional wellbeing.

This entire PhD process helped me to be more appreciative of those who have contributed to the literature and discussions on ethnic disparities in mental health services. The main thing I have taken away from this process is that there isn’t a perfect way to “do race” in research. Rather, there are several dilemmas and challenges that are inextricably linked with this topic. Instead of thinking about the enormity and painfulness of the topics as barriers to engaging with issues of oppression, marginalisation and racial or ethnic disparities, these dilemmas and challenges can serve as an opportunity to connect with the feelings of discomfort and pain that are necessary for real growth and change to take place. Instead of putting pressure on myself to produce the perfect thesis, I started to view this project as laying the foundation for future research and conversations. It was by understanding this, that everything had purpose and meaning - I was able to embrace the difficult feelings I experienced throughout and appreciate that this project is bigger than me. The possibility that my findings could positively impact on the lives of others kept me going.

10.2 Summary of the key contribution this study makes to the evidence base

The key original contribution of this study to the evidence base is its significant finding that, during MHA assessments, AMHPs place substantial value on an individual’s social capital when considering the necessity of compulsory detention. The study identified three critical aspects of social capital that were particularly influential in reducing the likelihood of detention:

1. **Emotional Support:** During mental health crises, especially those precipitated by stressful situations, support networks can assist individuals in finding solutions, diminishing the perceived severity of their problems, or providing necessary distractions. AMHPs noted that merely knowing they had potential support increased individuals' sense of self-efficacy and control.
2. **Reinforcement of Positive Behaviours:** AMHPs observed that family, friends, and social networks played a crucial role in encouraging individuals to adhere to prescribed medication

regimens, seek early voluntary treatment when their mental health began to deteriorate, and maintain healthy habits such as regular exercise and a balanced diet.

3. **Advocacy and Service Brokerage:** Social networks were essential in advocating for effective access to community mental health services, housing, employment, and training services for individuals who might otherwise be unable or unwilling to access these services independently.

This study's findings underscore the necessity for social policy to support interventions that create and sustain social networks for racialised communities and minimises re-traumatisation. It suggests that if the concept of social capital is to be utilised as a potential explanatory framework for understanding the disproportionality in detention rates of Black individuals under the MHA, this framework needs to be examined closely. This examination should include refining definitions of social capital, considering contextual indicators, and understanding the role of generalised trust in improving mental health outcomes for Black individuals. Special attention must be given to disadvantaged communities, particularly those lacking propinquity.

This study demonstrates that social capital may serve as a promising heuristic for future research on ethnic disproportionality in detention rates under the MHA. It offers mental health professionals, such as AMHPs and psychiatrists, insights for designing targeted interventions and provides policymakers with a paradigmatic approach to addressing longstanding mental health disparities. The relationship between social capital and various factors such as health, education, governmental efficacy, crime, and economic growth elucidates the importance of social capital in addressing long-standing ethnic disparities in the mental health system.

This research may have significant implications for Black mental health. The findings of this study can be used to demonstrate the complex work processes of integrated mental health and social care systems, enabling professionals to see the relations of power that mediate their work. Through such a raised awareness, professionals may understand the larger work process of which their own work is a part and may be better equipped to implement change. Additionally, Black service-users could provide perspectives on solutions and new models of care. This, in turn, may help to improve the social work service for people who use it and their carers and may continue to support the unique contribution of the social work profession in the field of mental health. It is this contribution that this doctoral study seeks to explore further, in an attempt to enhance the evidence base for mental health social work policy and practice in the 21st century.

10.3 Conclusion

This study took place during a contemporary moment in the world's history, the year 2020, which was marked by the rapid international spread of COVID-19, resulting in a pandemic not seen in a century. There is now substantial evidence from the pandemic in the UK that several Minority Ethnic groups have been

disproportionately affected and were at more risk of COVID-19 death than those from White backgrounds. For example, Black males had a 3.3 times greater risk than the White ethnic group (ONS, 2022). Socioeconomic circumstances were strongly related to risk of COVID-19 death (ONS, 2022). However, risk of death from COVID-19 was significantly lower where socioeconomic position was highest. Factors used to measure socioeconomic included educational attainment, occupation and tenure status, multigenerational household and household characteristics (gov.uk., 2022). This suggests, disparities in the access, distribution and quality of socioeconomic position and resources such as income, education and employment are primary mechanisms to explain ethnic disparities in health outcomes. Unsurprisingly, these findings echo the main findings of this study which found a significant link between a Black person's socioeconomic circumstances, and their likelihood of being compulsory detained under the MHA.

In order to redress the pervasive structural and systemic disadvantages faced by Black people, a reorientation of policy is required to one that recognises the ways in which mental health is affected by access to socio-economic mobility via pathways that include: the access to social capital, sustainable livelihoods, social cohesion and belonging in a community; education attainment; freedom from discrimination and numerous other factors. Holistic, rights-based, preventative approaches, co-produced and targeted at racialised and disadvantaged communities which engage with the social, economic and cultural determinants of mental health are necessary in order to tackle historical disadvantages and health inequalities. Moreover, within the literature, a strong evidence base is developing to demonstrate its applicability to social work and AMHP practice. The mental health implications of the COVID-19 pandemic have rendered these approaches even more necessary and relevant.

I will conclude by stating that the findings of this study and its implications should not be subsumed under another equality and diversity initiative. The fact that Black people continue to be disproportionately detained under the MHA and are overrepresented within the most coercive parts of the mental health system is a big enough issue on its own, and it deserves to be dealt with as such.

References

- Abbott, S. (2018). *Using the law in social work Approved Mental Health Professional practice* (Doctoral dissertation, University of Sussex).
- Abbott, S. (2022). A Study Exploring How Social Work AMHPs Experience Assessment under Mental Health Law: Implications for Human Rights-Oriented Social Work Practice, *The British Journal of Social Work*, Volume 52, Issue 3, Pages 1362–1379, <https://doi.org/10.1093/bjsw/bcab145>
- Abramovitz, M. (1993). Should all social work students be educated for social change? *Journal of Social Work Education*, 29(1), 6-11.
- Abramovitz, M. (1998). DSW, PhD, Social Work and Social Reform: An Arena of Struggle, *Social Work*, Volume 43, Issue 6, Pages 512–526, <https://doi.org/10.1093/sw/43.6.512>.
- Adewale, V., Ritchie, D. and Everhart Skeels, S. (2016) African-American and African perspectives on mental health: A pilot study of the pre and post colonial and slavery influences and their implications on mental health. *Journal of Communication in Healthcare Vol. 9* , 78-79. [online] Available at: <http://www.tandfonline.com/doi/full/10.1080/17538068.2016.1170316> [Accessed 1 Jan 2020].
- Afshari, R., Bhopal, R.S. (2002). Changing pattern of use of ‘ethnicity’ and ‘race’ in scientific literature. *International Journal of Epidemiology*, 31(5), 1074. [online] Available at: <https://doi.org/10.1093/ije/31.5.1074> [Accessed 30 Mar 2020].
- Agyemang, C., Bhopal, R., Bruijnzeels, M. (2005). Negro, Black, Black African, African Caribbean, African American or what? Labelling African origin populations in the health arena in the 21st century. *Journal of Epidemiology & Community Health* 59:1014-1018. [Online] Available at: <https://jech.bmj.com/content/jech/59/12/1014.full.pdf> [Accessed 2 April 2020].
- Alderwick H, Gottlieb LM. (2019) Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems. *Milbank Q*, 97 (2):407–19.
- Alderwick H, Gottlieb LM, Fichtenberg CM, Adler NE. (2018) Social Prescribing in the U.S. and England: Emerging Interventions to Address Patients’ Social Needs. *Am J Prev Med*;54(5):715–8.
- Aleong, R. (2018). *A systematic review of the barriers to accessing adult mental health services among members of Black and Minority Ethnic (BME) groups in England*. Bachelor of Arts (Hons), Social Work Dissertation, University of York.
- Aleong, R. (2019). *How can mental health professionals mitigate the overrepresentation of Black and Minority Ethnic (BME) people compulsory detained under the Mental Health Act? Perspectives of Social Worker Approved Mental Health Professionals (AMHPs) in England*. Master of Arts, (MA) Social Research Dissertation, University of York.
- Alexander, C. (2008) *(Re)thinking ‘Gangs’*. London: Runnymede Trust.
- Allen, M. (2017). *The Sage Encyclopaedia of Communication Research Methods* (Vols. 1-4). Thousand Oaks, CA: Sage.

- Allen, R. (2014). *The Role of the Social Worker in Adult Mental Health Services*. [online] British Association of Social Workers. Available at: https://www.basw.co.uk/system/files/resources/basw_112306-10_0.pdf [Accessed 21 Aug. 2023].
- Almedom, A.M. (2005). Social capital and mental health: an interdisciplinary review of primary evidence. *Soc Sci Med.*;61(5):943-64.
- Alshenqeeti, H. (2014). Interviewing as a data collection method: A critical review. *English Linguistics Research*, 3(1), 39-45.
- Anderson, K.K., Flora, N., Archie, S., Morgan, C., McKenzie, K. (2014). A meta-analysis of ethnic differences in pathways to care at the first episode of psychosis. *Acta Psychiatrica Scandinavica* 130:257–68. [Online] Available at: <https://doi.org/10.1111/acps.12254> [Accessed 1 Dec. 2021].
- Archer, M. S. (1995). *Realist Social Theory: The Morphogenetic Approach*. Cambridge: Cambridge University Press.
- Aspinall, P. J. (2002). Collective Terminology to Describe the Minority Ethnic Population: The Persistence of Confusion and Ambiguity in Usage. *Sociology*, 36(4), 803–816.
- Audini, B., Pearce, A. & Lelliott, P. (2000) Accuracy, completeness and relevance of Department of Health returns on provision of mental health residential accommodation: a data quality audit. *Journal of Mental Health*, 9, 365-370
- Bamford, J., Klabbers, G., Curran, E., Rosato, M., & Leavey, G. (2021). Social Capital and Mental Health Among Black and Minority Ethnic Groups in the UK. *Journal of immigrant and minority health*, 23(3), 502–510. <https://doi.org/10.1007/s10903-020-01043-0>
- Bansal, N., Karlsen, S., Sashidharan, S.P., Cohen, R., Chew-Graham, C.A. and Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLOS Medicine*, [online] 19(12), p.e1004139. Available at: <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004139> [Accessed 20 Aug. 2023].
- Barnard, H. and Turner, C. (2011). *Poverty and ethnicity: A Review of Evidence*. [online] Joseph Rowntree Foundation. Available at: <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/poverty-ethnicity-evidence-summary.pdf> [Accessed 20 May 2021].
- Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S. and Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, [online] 6(4), pp.305–317. doi: [https://doi.org/10.1016/s2215-0366\(19\)30027-6](https://doi.org/10.1016/s2215-0366(19)30027-6).
- Barron D.S., Holterman C., Shipster P., Batson S., Alam M. (2010), Seen but not heard: ethnic minorities' views of primary health care interpreting provision: a focus group study. *Primary Health Care Research and Development* 11, 132–141. [online] Available at: https://www.researchgate.net/publication/228502998_Seen_but_not_heard-ethnic_minorities%27_views_of_primary_health_care_interpreting_provision_A_focus_group_study [Accessed 22 Mar. 2021].
- Bartlett, P., Sandland, R. (2014). *Mental health law: Policy and practice* (4th ed.). Oxford: Oxford University Press.

BASW (2020). *What do Social Workers do?* [online] Available at <https://www.basw.co.uk/resources/become-social-worker/what-do-social-workers-do> [Accessed 20 Jan. 2020].

Bechely, L. N. (2005). *Could it be otherwise? Parents and the inequities of public school choice*. New York, NY: Routledge.

Beller, J. and Wagner, A., 2018. Loneliness, social isolation, their synergistic interaction, and mortality. *Health Psychology*, 37(9), p.808.

Bell, J. (1993). *Doing Your Research Project*. Buckingham, Philadelphia: Open.

Bentz, V. M., & Shapiro, J. J. (1998). *Mindful enquiry in social research*. Thousand Oaks, CA: Sage.

Berger, P.L. and Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Doubleday & Company, New York

Berger, R. (2015). *Now I see it, now I don't: researcher's position and reflexivity in qualitative research*. *Qualitative Research*, 15(2), 219–234. <https://doi.org/10.1177/1468794112468475>

Bhavnani, R., Mizra, H.S., & Meeto, V. (2005) *Tackling the roots of racism: Lessons for Success*. Bristol: Policy Press.

Bhopal, K. (2021). The Sewell report displays a basic misunderstanding of how racism works. *The Guardian*. [online] 31 Mar. Available at: <https://www.theguardian.com/commentisfree/2021/mar/31/sewell-report-racism-government-racial-disparity-uk> [Accessed 20 May 2021].

Bhopal R. (1997). Is research into ethnicity and health racist, unsound, or important science? *BMJ (Clinical research ed.)*, 314(7096), 1751–1756. <https://doi.org/10.1136/bmj.314.7096.1751>

Bhopal R. (2004). Glossary of terms relating to ethnicity and race: for reflection and debate. *Journal of epidemiology and community health*, 58(6), 441–445.

Bhopal. R. S., (2001). Race and ethnicity as epidemiological variables: centrality of purpose and context. *In: Macbeth H, ed. Ethnicity and health*. London: Taylor and Francis pp 21–40.

Bhugra, D., Hilwig, M., Hossein, B., Marceau, H., Neehall, J., Leff, J., Mallett, R. and Der, G. (1996). First-contact incidence rates of schizophrenia in Trinidad and one-year follow-up. *The British Journal of Psychiatry*, 169(5), pp.587-592.

Bhugra, D & Ayonrinde, O. (2001). 'Racism, racial life events and mental ill health', *Advances in Psychiatric Treatment*, vol. 7, no. 5, pp. 343. <https://doi.org/10.1192/apt.7.5.343>

Bhui, K., Fenton, S., Grewal, I., Karlsen, S., Lloyd, K., Nazroo, J., O'Connor, W., and Kerry Sproston, K. (2002). *Ethnic differences in the context and experience of psychiatric illness: a qualitative study*. [online] lemosandcrane.co.uk. London: The Stationery Office. Available at: <https://lemosandcrane.co.uk/resources/NatCen%20-%20Ethnic%20Differences%20in%20the%20context%20and%20experience%20of%20psychiatric%20illness.pdf> [Accessed 20 Aug. 2023].

Bhui K., Nazroo J., Francis J. et al. (2018). *The impact of racism on mental health*. [Online] Available at : <https://synergicollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf> [Accessed 18 June 2019]

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *British Journal of Psychiatry*, 105-16.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F. and Feder, G. (2003) "Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review," *The British Journal of Psychiatry*. Cambridge University Press, 182(2), pp. 105–116. doi: 10.1192/bjp.182.2.105.

Bignall, T., Jeraj, S., Helsby, E. and Butt, J. (2019). *Racial disparities in mental health: Literature and evidence review*. [online] Available at: <https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf> [Accessed 21 Aug. 2023].

Billett, S. (2001), "Learning through work: workplace affordances and individual engagement", *Journal of Workplace Learning*, Vol. 13 No. 5, pp. 209-214. <https://doi.org/10.1108/EUM0000000005548>

Biordi, D.L. and Nicholson, N.R. (2013). Social Isolation. *Chronic Illness: Impact and Intervention*, p.97.

Birks, M. & Mills, J. (2015). *Grounded theory: a practical guide*. 2nd ed. London: SAGE.

Bisaillon, L. (2012). Cordon sanitaire or healthy policy? *How prospective immigrants with HIV are organized by Canada's mandatory HIV screening policy* (Doctoral dissertation). [online] available at: <http://www.ruor.uottawa.ca/en/handle/10393/20643> [Accessed on 12 Oct 2021]

Blaxter, L., Hughes, C. and Tight, M. (2001). *How to Research Second Edition*. Philadelphia: Open University Press.

Blum, L. (2008). 'White privilege': A mild critique¹. *Theory and Research in Education*, 6(3), 309–321.[online] available at: <https://doi.org/10.1177/1477878508095586> [Accessed on 12 Oct 2021].

Boast, N. and Chesterman, P. (1995). Black People and Secure Psychiatric Facilities. *The British Journal of Criminology*, 35(2), pp.218–235. doi: <https://doi.org/10.1093/oxfordjournals.bjc.a048495>.

Bonnet, M & Moran, N 2020, 'Why Do Approved Mental Health Professionals Think Detentions under the Mental Health Act Are Rising and What Do They Think Should Be Done about It?', *British Journal of Social Work*, vol. 50, no. 2, pp. 616-633. <https://doi.org/10.1093/bjsw/bcaa001>

Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press.

Bowers, L., Simpson, A., Nijman, H. & Hall, C. (2008). Patient ethnicity and three psychiatric intensive care units compared: the Tompkins Acute Ward Study. *Journal of Psychiatric and Mental Health Nursing*, 15(3), pp. 195-202. doi: 10.1111/j.1365- 2850.2007.01211.x

Boydell, J. Van Os, J., Mckenzie, K., Allardyce, J., Goel, R., McCreddie, G. & Murray, R.M. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal*, 323, 1336-1338.

Boyd-Franklin, N. (1989). *Black families in therapy: A multi systems approach*. Guilford Press.

- Boyd-Franklin, N., & Shenouda, N. T. (1990). A Multisystems Approach to the Treatment of a Black, Inner-City Family with a Schizophrenic Mother. *American journal of orthopsychiatry*, 60(2), 186-195
- Bradby, H. (2010). Institutional Racism in Mental Health Services: The consequences of compromised conceptualisation. *Sociological Research Online*, [online] 15(3), pp.86–96. Available at: <https://journals.sagepub.com/doi/10.5153/sro.2197> [Accessed 20 Aug. 2023].
- Bradby, H. (2010). Institutional Racism in Mental Health Services: The consequences of compromised conceptualization. *Sociological Research Online*, 15, 8. [online] Available at: <http://www.socresonline.org.uk/15/3/8.html> [Accessed 22 Feb. 2021].
- Braun, V. and Clarke., V (2006). Using Thematic Analysis in Psychology. *Qualitative Research Psychology* 3 (2): 77-101. doi:10.1191/1478088706qp063oa.
- British Association of Social Workers (BASW), (1977). *Mental health crisis services – A new philosophy*. Birmingham: BASW
- British Association of Social Workers [BASW] (2015). *BASW Code of Ethics | British Association of Social Workers*. [online] available at: <https://www.basw.co.uk/about-basw/code-ethics> [Accessed 26 Feb. 2020]
- British Sociological Association (2017). *Statement of ethical practice*. [online] available at: https://www.britisoc.co.uk/media/24310/bsa_statement_of_ethical_practice.pdf [Accessed 26 Feb. 2020]
- Brooks, S.K., Webster, R.K., Smith, L.E., Woodland, L., Wessely, S., Greenberg, N. and Rubin, G.J. (2020). The Psychological Impact of Quarantine and How to Reduce it: Rapid Review of the Evidence. *The Lancet*, [online] 395(10227), pp.912–920. doi:[https://doi.org/10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8).
- Brown, D. (2006). Working the system: Re-thinking the institutionally organised role of mothers and the reduction of “risk” in child protection work. *Social Problems*, 53(3), 352-370.
- Brown, R. (2013). *The Approved Mental Health Professionals guide to mental health law* (3rd ed.). Exeter: Learning Matters.
- Bryant-Davis, T., & Ocampo, C. (2005). The Trauma of Racism: Implications for Counseling, Research, and Education. *The Counseling Psychologist*, 33(4), 574–578. <https://doi.org/10.1177/0011000005276581>
- Buckland, R. (2016). The Decision by Approved Mental Health Professionals to Use Compulsory Powers Under the Mental Health Act 1983: A Foucauldian Discourse Analysis. *British Journal of Social Work* 46 (1): 46-62. doi:10.1093/bjsw/bcu114
- Bunglawala, Z. (2019). Please, Don't Call Me BAME or BME! *Civil Service Blog*. [online] Available at: <https://civilservice.blog.gov.uk/2019/07/08/please-dont-call-me-bame-or-bme/> [Accessed 22 April 2020].
- Cabinet Office (2018). *Race Disparity Audit*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/race-disparity-audit> [Accessed 20 Aug. 2023].
- Cacioppo, J.T., Hughes, M.E., Waite, L.J., Hawkley, L.C. and Thisted, R.A., 2006. Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. *Psychology and aging*, 21(1), p.140.

- Calhoun, C. (1998), Community without Propinquity Revisited: Communications Technology and the Transformation of the Urban Public Sphere. *Sociological Inquiry*, 68: 373-397. <https://doi.org/10.1111/j.1475-682X.1998.tb00474.x>
- Calsyn, R. J., & Winter, J. P. (2002). Social support, psychiatric symptoms, and housing: A causal analysis. *Journal of Community Psychology*, 30(3), 247–259. <https://doi.org/10.1002/jcop.10004>
- Campbell, J. and Davidson, G. (2009). Coercion in the Community: A Situated Approach to the Examination of Ethical Challenges for Mental Health Social Workers, *Ethics and Social Welfare*, 3(3), pp. 249–263. [Online] Available at: <https://doi.org/10.1080/17496530903209469> [Accessed 14 Nov. 2020].
- Campbell, J., Brittan, F., Hamilton, B., Hughes, P., Manteklow, R. and Wilson, G. (2001). The Management and Supervision of ASWs: Aspects of law, policy and practice, *The Journal of Social Welfare and Family Law*, 23(2), pp. 155- 172.
- Campbell, J.D. (2010). Deciding to Detain: The use of Compulsory Mental Health Law by UK Social Workers. *British Journal of Social Work*, 40, pp. 328- 334. [Online] Available at: <https://doi.org/10.1093/bjsw/bcp121> [Accessed 25 Nov. 2020].
- Campbell, M., & Gregor, F. (2002). *Mapping Social Relations: A Primer in Doing Institutional Ethnography* (2nd ed.). University of Toronto Press: Toronto
- Campbell, M., & Gregor, F. (2004). *Mapping social relations: A primer in doing institutional ethnography*. Walnut Creek, CA: Alta Mira Press.
- Care Quality Commission (2011). *Count me in 2010 Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. [online] Available at: http://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf [Accessed 20 Aug. 2023].
- Care Quality Commission [CQC] (2022). *The state of health care and adult social care in England 2021/22*. Available online at: <https://www.cqc.org.uk/publication/state-care-202122> Accessed 11 Mar 2023
- CARICOM (2022). *Our People*. [online] CARICOM Caribbean Community. Available at: <https://caricom.org/our-community/who-we-are/our-people/> [Accessed 5 Aug. 2022].
- Carlson, E. B. (1997). *Trauma assessments: Clinician's guide*. New York: Guilford
- Carmichael, S., Cooper, D., Laing, R. D., & Marcuse, H. (2015). *The dialects of liberation*. Verso.
- Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. (2003). Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work*, 33, pp.1081-1103. [Online] Available at: <https://doi.org/10.1093/bjsw/33.8.1081> [Accessed 30 Aug. 2020]
- Carroll, W. K. (2010). 'You are here': Interview with Dorothy E. Smith. *Socialist Studies*, 6(2), 9-37.
- Carter, R. T. (2007). Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress. *The Counselling Psychologist*, 35(1), 13–105. <https://doi.org/10.1177/0011000006292033>

- Catalano R., Goldman-Mellor S., Saxton K., Margerison-Zilko C., Subbaraman M., LeWinn K. (2011). The Health Effects of Economic Decline. *Annual Review of Public Health* 32:431-50.
- Centre for Mental Health (2013). *The Bradley Commission. Black and Minority Ethnic Communities, Mental Health and Criminal Justice*. [online] Available at: Bradley_Commission_briefing1_BME.pdf (centreformentalhealth.org.uk) Accessed 23 August 2021.
- Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). *Linking symbolic interactionism and grounded theory methods in a research design: from Corbin and Strauss' assumptions to action*. SAGE Open. [Online] available at <https://doi.org/10.1177/2158244013505757> [Accessed 8 Oct 2021].
- Charmaz, K. (2012). The Power and Potential of Grounded Theory. *Medical Sociology Online*, 6, 2-15.
- Chorlton E, McKenzie K, Morgan C, Doody G. (2012). Course and outcome of psychosis in Black Caribbean populations and other ethnic groups living in the UK: A systematic review. *International Journal of Social Psychiatry*, 58(4):400-408. doi:10.1177/0020764011403070
- Claridge, T. (2018). *Introduction to Social Capital Theory SOCAP101 Tristan Claridge*. [online] Available at: <https://www.socialcapitalresearch.com/wp-content/uploads/edd/2018/08/Introduction-to-Social-Capital-Theory.pdf> [Accessed 5 Aug. 2020].
- Clark, C. (2006). *The British Journal of Social Work* Vol. 36, No. 1 (2006), pp. 75-89
- CNN (2022), The amazing new Swiss mountain train that can jump rail tracks. [online] Available at: [The amazing new Swiss mountain train that can jump rail tracks | CNN](#) Accessed 30 August 2023
- Coffey, A., & Atkinson, P. (1996). *Making Sense of Qualitative Data: Complementary Research Strategies*. Thousand Oaks, CA: Sage.
- Coffey, M. and Hannigan, B., (2013). New roles for nurses as approved mental health professionals in England and Wales. *International Journal of Nursing Studies*, 50(10), pp.1423-1430.
- Cogan, N., MacIntyre, G., Stewart, A., Tofts, A., Quinn, N., Johnston, G., Hamill, L., Robinson, J., Igoe, M., Easton, D., McFadden, A. and Rowe, M. (2020). 'The biggest barrier is to inclusion itself': the experience of citizenship for adults with mental health problems. *Journal of Mental Health*, 3(30), pp.1–8. doi:<https://doi.org/10.1080/09638237.2020.1803491>.
- Collier, M. J., & Thomas, M. (1988). *Cultural Identity: An Interpretive Perspective*. Thousand Oaks, CA: Sage.
- Collier, M. J. (2009). Cultural identity theory. In S. W. Littlejohn & K. A. Foss (Eds.), *Encyclopaedia of communication theory* (Vol. 1, pp. 260–262). Thousand Oaks, CA: SAGE
- Collins, C. S., & Stockton, C. M. (2018). The Central Role of Theory in Qualitative Research. *International Journal of Qualitative Methods* <https://doi.org/10.1177/1609406918797475>
- Collins, P.H. (1990). *Black feminist thought: knowledge, consciousness and the politics of empowerment*. Boston: Unwin Hyman,
- Collins, P.H. (1998), It's All in the Family: Intersections of Gender, Race, and Nation. *Hypatia*, 13: 62-82. <https://doi.org/10.1111/j.1527-2001.1998.tb01370.x>

- Collins, P. H. (2000) 'Gender, Black Feminism, and Black Political Economy', *The ANNALS of the American Academy of Political and Social Science*, 568(1), pp. 41–53. doi: 10.1177/000271620056800105.
- Collins P.H. (2016). Black Feminist Thought as Oppositional Knowledge. *Departures in Critical Qualitative Research* 5 (3): 133–144. doi: <https://doi.org/10.1525/dcqr.2016.5.3.133>
- Commission on Race and Ethnic Disparities (2021). *The report of the Commission on Race and Ethnic Disparities*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities> [Accessed 8 Aug. 2021].
- Cooper, D. (1967). *Psychiatry and Anti-psychiatry* (pp. 1-23). Tavistock.
- Corrigall R., Bhugra D., (2013). The role of ethnicity and diagnosis in rates of adolescent psychiatric admission and compulsory detention: a longitudinal case-note study. *J R Soc Med* 106(5):190–195
- Crenshaw. K. (2017). *Kimberlé Crenshaw on Intersectionality, More than Two Decades Later*. [online] www.law.columbia.edu. Available at: <https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later> [Accessed 23 Aug. 2023].
- Creswell, J.W. and Creswell, J.D. (2018). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (5th ed.). Thousand Oaks: SAGE.
- Creswell, J.W. and Poth, C.N. (2018). *Qualitative Inquiry and Research Design Choosing among Five Approaches*. 4th Edition, SAGE Publications, Inc., Thousand Oaks.
- Crichton, J.H.M. (1994). Comments of the Blackwood Enquiry. *Psychiatric Bulletin* 18, 236-237.
- Cross, M. (2013). Rethinking epistemic communities twenty years later. *Review of International Studies*, 39(1), 137-160.
- Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process* London: Sage Publications.
- Crown Prosecution Service (2023). *CPS charging decisions - examining demographic disparities in the outcomes of our decision-making | The Crown Prosecution Service*. [online] www.cps.gov.uk. Available at: <https://www.cps.gov.uk/publication/cps-charging-decisions-examining-demographic-disparities-outcomes-our-decision-making> [Accessed 23 Aug. 2023].
- Cushion, S., Moore, K. and Jewell, J. (2011). *Media Representations of Black Young Men and Boys Report of the REACH Media Monitoring Project*. [online] Available at: <https://core.ac.uk/download/pdf/8817683.pdf> [Accessed 5 Aug. 2020].
- Das-Munshi, J., Bhugra, D. & Crawford, M.J. (2018). Ethnic Minority inequalities in access to treatments for schizophrenia and schizoaffective disorders: findings from a nationally representative cross-sectional study. *BMC Med* 16, 55.
- Davidson, G., Brophy, L. and Campbell, J. (2016). Risk, Recovery and Capacity: Competing or Complementary Approaches to Mental Health Social Work'. *Australian Social Work*, 69(2), pp. 158-168. [Online] Available at: <https://doi.org/10.1080/0312407X.2015.1126752> [Accessed 30 Aug. 2020].

- De Montigny, G. (1995). *Social Working: an ethnography of frontline practice*. University of Toronto press.
- DeNiro D. A. (1995). Perceived alienation in individuals with residual-type schizophrenia. *Issues in mental health nursing*, 16(3), 185–200. <https://doi.org/10.3109/01612849509006934>
- Denscombe, M. (2003). *The Good Research Guide*. 2nd edn. Open University Press, Maidenhead
- Denscombe, M. (2017). *EBOOK: The good research guide: For small-scale social research projects*. McGraw-Hill Education (UK).
- Denzin, N. and Lincoln, Y.S. (2011). *The Sage Handbook of Qualitative Research*. Thousand Oaks: Sage
- Denzin, N.K. & Lincoln, Y.S. (2018). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.) *The Sage Handbook of Qualitative Research, 5th Ed*. Thousand Oaks: Sage
- Denzin, N. K. & Lincoln, Y. S. (2008). *Strategies of qualitative inquiry (3rd ed.)*. Thousand Oaks, CA: Sage.
- Department of Health (1999). *Modern Standards and Service Models*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf [Accessed 20 Aug. 2023].
- Department of Health (2005). *Delivering race equality in mental health care*. Department of Health. London.
- Department of Health and Social Care (2018). *Modernising the Mental Health Act – final report from the independent review*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> [Accessed 21 Aug. 2023].
- Department of Health and Social Care (2021). *Reforming the Mental Health Act (White Paper)*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf [Accessed 21 Aug. 2023].
- Department of Health and Social Care (2023). *Approved Mental Health Professional (AMHP) workforce*. [online] www.skillsforcare.org.uk. Available at: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx#:~:text=There%20are%20an%20estimated%203%2C800> [Accessed 20 Aug. 2023].
- Department of Health and Social Care (2015). *Mental Health Act 1983: Reference Guide*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/mental-health-act-1983-reference-guide> [Accessed 21 Aug. 2023].
- Department of Health and Social Care [DHSC] (2015). *Mental Health Act 1983: Code of Practice*. [online] GOV.UK. The Stationery Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF [Accessed 21 Aug. 2023].

- Department for Education and Skills [DES] (1985). *Education for all. The report of the committee of enquiry into the education of children from Ethnic Minority groups* (the Swann report). London: HMSO.
- DeVault, M. (2006). What is institutional ethnography? *Social Problems*, 53(3), 294-298.
- Devault, M.L. (1991). *Feeding the Family: The Social Organization of Caring as Gendered Work*. Chicago: University of Chicago Press.
- DeVault, M. L., & McCoy, L. (2001). Institutional ethnography: Using interviews to investigate ruling relations. In J. F. Gubrium and J.A. Holstein (Eds.), *Handbook of interview research: Context and methods*. Thousand Oaks: Sage Publications.
- Diamond, T. (1992). *Making Gray Gold*. Chicago: University of Chicago Press.
- Diamond, T. (2006). "Where did you get the fur coat from Fern?" Participant Observation in Institutional Ethnography. In: Smith, D. E. (ed.) *Institutional ethnography as practice*. Oxford: Rowman & Littlefield.
- Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R. and Sutton, A.J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, 6(35). [Online] Available at: <https://doi.org/10.1186/1471-2288-6-35> [Accessed 22 Nov. 2020].
- Docking, M. (2009). The use of section 136 to detain people in police custody. *International Journal of Mental Health and Capacity Law*, (18), pp.33–44. doi: <https://doi.org/10.19164/ijmhcl.v0i18.277>.
- Douglas, J. (1964). *The home and the school: A study of ability and attainment in the primary school*. London: MacGibbon & Kee
- DuBois, W. E. B. (2007). *The Souls of Black Folk* (pp. 7-14). Oxford University Press.
- Dwyer, S. (2012). Walking the Tightrope of a Mental Health Act Assessment. *Journal of Social Work Practice* 26 (3): 341-353. doi:10.1080/02650533.2011.629293
- Eaton, W. W. & Harrison, G. (2000) Ethnic disadvantage and schizophrenia. *Acta Psychiatrica Scandinavica*, 102 (suppl. 407),1 -6.
- Edge, D. and MacKian C. (2010). Ethnicity and mental health encounters in primary care: help-seeking and help-giving for perinatal depression among Black Caribbean women in the UK, *Ethnicity and Health*,15:1, 93-111. [online] Available at: <https://www.ncbi.nlm.nih.gov/pubmed/20077242> [Accessed 22 Feb. 2020].
- Edwards, P. K., O'Mahoney, J., & Vincent, (2014). *Studying organizations using critical realism: A practical guide S. (Eds.)*. Oxford: Oxford University Press.
- Elliott, I. (June 2016) *Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy*. London: Mental Health Foundation.
- Emerson, R., Pollner, M. (1976). Dirty work designations: Their features and consequences in a psychiatric setting, *Social Problems*, vol. 233 (p 243-54). [Online] Available at: <https://doi.org/10.2307/799771> [Accessed 22 Oct. 2021].

- Emmel, N. (2013). *Sampling and choosing cases in qualitative research: A realist approach*. Los Angeles: Sage.
- Erens, B., Primatesta, P., & Prior, G. (2001). *Health survey for England. The health of Minority Ethnic groups 1999* (Vol.2: Methodology & Documentation). London: The Stationary Office.
- Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing Naturalistic Inquiry: A Guide to Methods*. Newbury Park, CA: Sage.
- Fatimilehin, I. A. and Coleman, P. G. (1999), 'You've got to have a Chinese chef to cook Chinese food!!' Issues of power and control in the provision of mental health services. *J. Community. Appl. Soc. Psychol.*, 9: 101–117. [online] Available at: <http://www.justpsychology.co.uk/node/49> [Accessed 22 Dec. 2022].
- Faulkner, A. (2014) *Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change. A Consultation with Black and Minority Ethnic Mental Health Service Users*. London: National Survivor User Network. [online] Available at: <https://lankellychase.org.uk/wp-content/uploads/2015/07/Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf> [Accessed 22 Feb. 2021]
- Faulkner, S.L. and Trotter, S.P. (2017). Data Saturation. In *The International Encyclopedia of Communication Research Methods* (eds J. Matthes, C.S. Davis and R.F. Potter). <https://doi.org/10.1002/9781118901731.iecrm0060>
- Feagin, J.R. (2004). Toward an integrated theory of systemic racism. *The changing terrain of race and ethnicity*, pp.203-223.
- Fearon, P., Kirkbride, J.B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Fung, W.L.A., Holloway, J. and Mallett, R., (2006). Incidence of schizophrenia and other psychoses in Ethnic Minority groups: results from the MRC AESOP Study. *Psychological medicine*, 36(11), pp.1541-1550.
- Feinstein, A. & Holloway, F. (2002), Evaluating the use of a psychiatric intensive care unit: Is ethnicity a risk factor for admission? *International Journal of Social Psychiatry*, vol. 48, no. 1, pp. 38-46.
- Ferguson, H. (2010). Therapeutic journeys: the car as a vehicle for working with children and families and theorising practice. *Journal of Social Work Practice*, 24: 121–138
- Fernando, D.S., & Keating, F. (Eds.). (2008). *Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook* (2nd ed.). Routledge. <https://doi.org/10.4324/978020389553>
- Fernando, S. (1988). *Race and culture in psychiatry*. Tavistock: London.
- Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), 209–230. <https://doi.org/10.1177/146879410200200205>
- Finn, J. L. & Jacobson, M. (2003). Just Practice, *Journal of Social Work Education*, 39:1, 57-78, DOI: 10.1080/10437797.2003.10779119.
- Fisher, R. (1995). Political Social Work. *Journal of Social Work Education*, 31(2), 194–203. <http://www.jstor.org/stable/23042989>

Fistein, E. C., Clare, C.H., Redley, M. and Holland, A. J. (2016). Tensions Between Policy and Practice: A Qualitative Analysis of Decisions Regarding Compulsory Admission to Psychiatric Hospital. *International Journal of Law and Psychiatry* 46: 50-57. doi:10.1016/j.ijlp.2016.02.029.

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

Foucault, M. (1979). *Discipline and punish*. New York: Vintage Books.

Fox, R.C. (2000). Medical uncertainty revisited. In Albrecht, G., Fitzpatrick, R. and Scrimshaw, S. (eds) *Handbook of Social Studies in Health and Medicine*. London: Sage.

Francis, J.J., Johnston, M., Robertson C., Glidewell, L., Entwistle, V., Eccles, M.P., Grimshaw, J.M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychol Health*.25(10):1229-45.

Francis-Devine, B., Booth, L. and Mcguinness, F. (2021). *Poverty in the UK: statistics, House of Commons Briefing Paper Number 7096*. [online] Available at: [https://dera.ioe.ac.uk/id/eprint/34239/1/SN07096%20\(1\).pdf](https://dera.ioe.ac.uk/id/eprint/34239/1/SN07096%20(1).pdf) [Accessed 23 Aug. 2020].

Frank, J. (2003). Making Social Capital Work for Public Policy. In: *Policy Research Initiative* (ed) (2003): Horizons. Volume 6, No. 3, pp. 3-6.

Franklin, A. J., Boyd-Franklin, N., & Kelly, S. (2006). Racism and invisibility: Race-related stress, emotional abuse and psychological trauma for people of colour. *Journal of Emotional Abuse*, 6(2-3), 9-30.

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2016). Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research. *Psychological Bulletin*.

Furminger, E. & Webber, M. (2009). The Effect of Crisis Resolution and Home Treatment on Assessments under the 1983 Mental Health Act: An Increased Workload for Approved Social Workers? *British Journal of Social Work*, 39(5), pp. 901-917. [Online] Available at: <https://doi.org/10.1093/bjsw/bcm171> [Accessed 22 Nov. 2020].

Furukawa, T.A. (2019). An epidemic or a plaque of common mental disorders? *Acta Psychiatr Scand*. 140: 391-392.

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. P. (2016). Ethnicity and detention: are Black and Minority Ethnic (BME) groups disproportionately detained under the Mental Health Act 2007? *Social Psychiatry and Psychiatric Epidemiology*, 51, 703–711. [online] Available at: <http://doi.org/10.1007/s00127-016-1181-z> [Accessed 23 Nov. 2020].

Gale, N. K., Thomas, G. M., Thwaites, R., Greenfield, S., and Brown, P. (2016) Towards a sociology of risk work: A narrative review and synthesis. *Sociology Compass*, 10: 1046– 1071. doi: 10.1111/soc4.12416.

Garety P.A., Kuipers E., Fowler D., Freeman D., Bebbington P.E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychol Med*. 31(2):189–195. doi: 10.1017/S0033291701003312.

- Gibbons F.X., O'Hara R.E., Stock M.L., et al. (2012) The erosive effects of racism: reduced self-control mediates the relation between perceived racial discrimination and substance use in African American adolescents. *Journal of Personality and Social Psychology*, 102(5), 1089-104.
- Gillispie, R., Williams, E., & Gillispie, C. (2005). Hospitalized African American Mental Health Consumers: Some Antecedents to Service Satisfaction and Intent to Comply with Aftercare. *American Journal of Orthopsychiatry*, 75(2), 254–261. <https://doi.org/10.1037/0002-9432.75.2.254>
- Glover-Thomas, N. (2018). Decision-Making Behaviour under the Mental Health Act 1983 and Its Impact on Mental Health Tribunals: An English Perspective. *Laws* 7 (2) 12: 1-23. doi:10.3390/laws7020012.
- Glover, G., & Evison, F. (2009). *Use of new mental health services by ethnic minorities in England*. Durham, England: North East Public Health Observatory.
- Glover, G. and Evison, F. (2009). *Use of new mental health services by ethnic minorities in England*: North East Public Health Observatory. [online] Available at: <https://www.scie-socialcareonline.org.uk/use-of-new-mental-health-services-by-ethnic-minorities-in-england/r/a11G00000017zljIAA> [Accessed 25 Nov. 2020].
- Gobo, G. (2008). What is ethnography? In Gobo, G. *Introducing Qualitative Methods: Doing ethnography* (pp. 2-14). London: SAGE Publications Ltd
- Goemans (2012). A consideration of the nature and purpose of mental health social work. *Mental Health and Social Inclusion* Vol. 16 No. 2 2012, pp. 66-73. [online] Available at: http://eprints.lincoln.ac.uk/6284/1/MH%26SE_article_may12.pdf [Accessed 20 Jan. 2020].
- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). Institute of Medicine (US) Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, *Reducing Suicide: A National Imperative*. National Academies Press (US).
- Gostin, L., (1975). *A Human Condition*. Volume 1. London: Mind.
- Gough B (2003). Deconstructing reflexivity. In: Finlay L and Gough B (eds) *Reflexivity: A practical guide for researchers in health and social sciences* pp. 21–35 Oxford: Blackwell Science Ltd.
- GOV.UK (2018). *Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf [Accessed 20 Aug. 2023].
- Gov.uk (2019). *National workforce plan for approved mental health professionals (AMHPs)*. [online] Available at: <https://www.gov.uk/government/publications/national-workforce-plan-for-approved-mental-health-professionals-amhps> [Accessed 20 Jan. 2020].
- GOV.UK (2019). *Race and the criminal justice system*. [online] GOV.UK. Available at: <https://www.gov.uk/government/collections/race-and-the-criminal-justice-system#history> [Accessed 23 Aug. 2020].
- GOV.UK (2020b). Why we're talking more about how we collect and analyse data on ethnicity. *Race Disparity Unit*. [online] available at: <https://dataingovernment.blog.gov.uk/2020/04/17/why-were-talking-more-about-how-we-collect-and-analyse-data-on-ethnicity/> [Accessed 20 April 2020]

- GOV.UK (2020c). *People Without Decent Homes, Ethnicity Facts and Figures* [Online] Available at: <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/non-decent-homes/latest> [Accessed August 20, 2022]
- GOV.UK (2021a). *Psychotic disorders*. [online] www.ethnicity-facts-figures.service.gov.uk. Available at: <https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-a-psychotic-disorder/latest> [Accessed 20 Aug. 2023].
- GOV.UK (2021b). *Unemployment*. [online] Service.gov.uk. Available at: <https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/unemployment-and-economic-inactivity/unemployment/latest> [Accessed 23 Aug. 2022].
- GOV.UK (2022). *Mental Health Act Statistics, Annual Figures, 2021-22*. [online] GOV.UK. Available at: <https://www.gov.uk/government/statistics/mental-health-act-statistics-annual-figures-2021-22> [Accessed 20 Aug. 2023].
- GOV.UK (2020a). *Ethnicity facts and figures: List of ethnic groups*. [online] available at: <https://www.ethnicity-facts-figures.service.gov.uk/ethnic-groups> [Accessed 20 Jan. 2020].
- Gray, D.E. (2018). *Doing research in the real world, 4th ed.* London: Sage.
- Gregor, C. (2010). Unconscious Aspects of Statutory Mental Health Social Work: Emotional Labour and the Approved Mental Health Professional. *Journal of Social Work Practice* 24 (4): 429-443. doi:10.1080/02650531003791012.
- Griffith, A., & Smith, D. (Eds.). (2014). *Under New Public Management: Institutional Ethnographies of Changing Front-Line Work*. Toronto; Buffalo; London: University of Toronto Press. doi:10.3138/j.ctt7zwbzq
- Griffiths, S. (2009). A programme for changing attitudes in the statutory sector: dialogue is critical. In S. Fernando, & F. Keating (Eds.), *Mental Health in a Multi -Ethnic Society*. Hove: Routledge.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications, Inc.
- Gunter, A. (2017). *Race, Gangs and Youth Violence*. [online] Policy Press. Available at: <https://policypress.co.uk/race-gangs-and-youth-violence#sthash.TE2BaYii.dpuf> [Accessed 23 Aug. 2020].
- Haas, P. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization*, 46(1).
- Hall C., Juhila K., Matarese M., van Nijnatten C. (2014). *Analyzing Social Work Communication*. Abingdon Oxon: Routledge.
- Hall, P. (2017). Mental Health Act Assessments - Professional Narratives on Alternatives to Hospital Admission. *Journal of Social Work Practice* 31 (4): 445-459. doi:10.1080/02650533.2017.1394825
- Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E. and Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC Medicine*, [online] 16(1). Available at: <https://doi.org/10.1186/s12916-018-1201-9> [Accessed 20 Aug. 2023].

- Hamilton, I. (2017) Cannabis, psychosis and schizophrenia: unravelling a complex interaction. *Addiction*, 112: 1653– 1657. doi: 10.1111/add.13826.
- Han, J. and Richardson, V.E. (2010). The relationship between depression and loneliness among homebound older persons: Does spirituality moderate this relationship? *Journal of Religion & Spirituality in Social Work: Social Thought*, 29(3), pp.218-236.
- Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies*, 14(3), 575–599. <https://doi.org/10.2307/3178066>
- Harding, S. (1988). The Science Question in Feminism. *Synthese* 76 (3):441-446.
- Harper, D. (2022). *Online etymology dictionary*. [online] Etymonline.com. Available at: <https://www.etymonline.com/> [Accessed 21 Aug. 2023].
- Hatfield, B. (2008). Powers to Detain under Mental Health Legislation in England and the Role of the Approved Social Worker: An Analysis of Patterns and Trends under the 1983 Mental Health Act in Six Local Authorities. *British Journal of Social Work*, 38(8), pp. 1553-1571. [Online] available at: <https://doi.org/10.1093/bjsw/bcm046> [Accessed 12 Nov 2020].
- Hatfield, B. (2013). Social Work Practice and Mental Illness. *The Blackwell Companion to Social Work*, p.275.
- Hatfield, B., Huxley, P. and Mohamad, H. (1997). Social Factors and Compulsory Detention of Psychiatric Patients in the UK: The Role of Approved Social Workers in the 1983 Mental Health Act. *International Journal of Law and Psychiatry*, 20(3), pp. 389-397.
- Hausmann, L. R. M., Gao, S., Lee, E. S., & Kwoh, K. C. (2013). Racial disparities in the monitoring of patients on chronic opioid therapy. *Pain*, 154(1), 46–52. <https://doi.org/10.1016/j.pain.2012.07.034>
- Hawker, M., & Romero-Ortuno, R. (2016). Social Determinants of Discharge Outcomes in Older People Admitted to a Geriatric Medicine Ward. *The Journal of frailty & aging*, 5(2), 118–120. <https://doi.org/10.14283/jfa.2016.89>
- Haynes, R. (1990). After 1983: Approved Social Workers' Perceptions of Their Changing Role in Emergency Psychiatric Assessments. *Practice* 4 (3) 184-198. doi:10.1080/09503159008416894.
- Helms, J. E., Nicolas, G., & Green, C. E. (2010). Racism and Ethnoviolence as Trauma: Enhancing Professional Training. *Traumatology*, 16(4), 53–62. <https://doi.org/10.1177/1534765610389595>
- Heppner, P. P., Kivlighan, D. M., Jr., & Wampold, B. E. (1999). *Research Design in Counselling* (2nd ed.). Belmont, CA: Wadsworth.
- Hickling, F.W. (2020). *Enslaved minds: Decolonising Mental Health*. [online] www.acu.ac.uk. Available at: <https://www.acu.ac.uk/the-acu-review/enslaved-minds/> [Accessed 4 Jul. 2021].
- Hickling, F.W. (2005). The epidemiology of schizophrenia and other common mental health disorders in the English-speaking Caribbean. *Pan American Journal of Public Health*, 18(4-5), 256-262. <http://www.sciencedirect.com/science/article/pii/S0277953602000631> [Accessed 22 Nov. 2020].
- Hickling, F.W. and Rodgers-Johnson, P. (1995). The incidence of first contact schizophrenia in Jamaica. *The British Journal of Psychiatry*, 167(2), pp.193-196.

- Hickling, F.W., McKenzie, K., Mullen, R. and Murray, R. (1999). A Jamaican psychiatrist evaluates diagnoses at a London psychiatric hospital. *The British Journal of Psychiatry*, 175(3), pp.283-285.
- Hicks, S. (2009). Sexuality and the 'Relations of Ruling': Using Institutional Ethnography to Research Lesbian and Gay Foster Care and Adoption, *Social Work and Society International Journal* Vol7 No2. [Online] available at: <https://www.socwork.net/sws/article/view/75/334> [accessed 10 April 2020].
- Higgins J.P.T., Thomas J., Chandler J., Cumpston M., Li T., Page M.J., Welch V.A. (2023). *Cochrane Handbook for Systematic Reviews of Interventions* version 6.4
- Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A Guide to Conducting Consensual Qualitative Research. *The Counseling Psychologist*, 25(4), 517–572. <https://doi.org/10.1177/0011000097254001>
- Hill, C., Knox, E., Thompson, S., Barbara J., Williams, E., et al (2005). Consensual Qualitative Research: An Update. *College of Education Faculty Research and Publications*. 18.
- Hines, P. M. & Boyd-Franklin (2005), N. African American Families. In M. McGoldrick & J. Giordano (Eds.), *Ethnicity and Family Therapy* (pp. 87-100). The Guilford Press
- HM Government (2011). *No Health without Mental Health a cross-government Mental Health Outcomes Strategy for People of All Ages*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf [Accessed 21 Aug. 2023].
- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, 113(16), 4296–4301. <https://doi.org/10.1073/pnas.1516047113>
- Holroyd, J., Sweetman, J. (2016). The Heterogeneity of Implicit Bias. In Brownstein, Michael, Saul, Jennifer, editors. *Implicit Bias and Philosophy, Volume 1: Metaphysics and Epistemology* 1. p. 80–103. Oxford: Oxford University Press.
- Holstein, J., & Gubrium, J. (1995). *The Active Interview*. Thousand Oaks: Sage.
- Home Office. (2020). *Windrush lessons learned review: Independent review by Wendy Williams*
- Hom, M.A., Stanley, I.H., Podlogar, M.C. and Joiner Jr, T.E. (2017). “Are you having thoughts of suicide?” Examining experiences with disclosing and denying suicidal ideation. *Journal of Clinical Psychology*, 73(10), pp.1382-1392.
- Hooks, B. (1992). Yearning: Race, gender, and cultural politics. *Hypatia*, 7(2).
- Horlick-Jones, T. (2005). On 'risk work': Professional discourse, accountability, and everyday action, *Health, Risk & Society*, 7:3, 293-307, DOI: 10.1080/13698570500229820
- Horton, R. (2017). *Offline: Racism—the pathology we choose to ignore*. The Lancet, 390(10089), 14.
- House of Commons (2018), *Women and Equalities Committee Race Disparity Audit Third Report of Session 2017–19 (HC 562)*. [Online] Available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/562/562.pdf> [Accessed 22 Aug. 2020].

Houston, S. (2010). 'Prising Open the Black Box: Critical Realism, Action Research and Social Work', *Qualitative Social Work*, 9(1), pp. 73–91.

Howard, M. (2010). Social Workers as Public Intellectuals. *Social Work Research*, 34(3), 131-133. [Online] available at: <http://www.jstor.org/stable/42659757> [Accessed 13 July 2021]

Hughes, E. C. (1971). *The Sociological Eye: Selected Papers*, Chicago Aldine-Atherton.

Hussenoeder, F. S. (2022). Social network sites as learning environments and their implications for mental health. *Frontiers in digital health*, 4, 939740. <https://doi.org/10.3389/fdgth.2022.939740>

Institute for Government (2021). *Annex: 2019 Conservative Manifesto Table of Pledges*. [online] www.instituteforgovernment.org.uk. Available at: <https://www.instituteforgovernment.org.uk/sites/default/files/annex-conservative-manifesto-half-time-analysis.pdf> [Accessed 8 Aug. 2023].

Institute of Health Equality (2012). *The impact of the economic downturn and policy changes on health inequalities in London*. London: UCL IHE, 2012.

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US).

Isaac, M., Isaac, M., & Holloway, F. (2005), Is cannabis an anti-psychotic? The experience in psychiatric intensive care, *Human Psychopharmacology: Clinical and Experimental*, vol. 20, no. 3, pp. 207-210.

Islam, Z., Rabiee, F., and Singh, S.P. (2015). Black and Minority Ethnic groups' perception and experience of early intervention in psychosis services in the United Kingdom. *Journal of Cross-Cultural Psychology*; 46:737–753. [online] Available at: <http://journals.sagepub.com/doi/abs/10.1177/0022022115575737> [Accessed 1 Dec. 2021].

Iversen, C. (2014). Predetermined participation social workers evaluating children's agency in domestic violence interventions. *Childhood*, 21(2), 274– 289.

Jacobsen, K. H. (2020). *Introduction to Health Research Methods: A Practical Guide*. United States: Jones & Bartlett Learning.

Jamaica Constabulary Force (2022). *Serious Crimes Report for January 1 to August 26, 2023 and comparative period for 2022*. [online] Jamaica Constabulary Force. Available at: <https://jcf.gov.jm/stats/> [Accessed 5 May 2023].

Jarman, B., Hirsch, S., White, P., et al (1992). Predicting Psychiatric Admission Rates. *British Medical Journal*, 304, pp. 1146-1151.

Jeraj, S., Shoham, T. and Islam-Barrett, F. (2015), *Mental Health Crisis Review: Experience of Black and Minority Ethnic Communities*, Race Equality Foundation, London. [online] Available at: <http://www.raceequalityfoundation.org.uk/resources/downloads/mental-health-crisis-review---experiences-black-and-minority-ethnic-> [Accessed 16 Mar Dec. 2021].

Jessica L. H. Fish (2022) The lost social perspective: relocating the social perspective in approved mental health practice and the Mental Health Act 1983, *Journal of Social Welfare and Family Law*, 44:1, 3-21, DOI: 10.1080/09649069.2022.2028391

- Johnson R, Griffiths C, Nottingham T (2006) *At home? Mental health issues arising in social housing*. National Institute for Mental Health in England.
- Jones R., (2022) *Mental Health Act Manual* (25th ed) Sweet and Maxwell: London
- Jordan, L.C., Bogat, G.A. and Smith, G., (2001). Collaborating for social change: The Black psychologist and the Black community. *American Journal of Community Psychology*, 29(4), pp.599-620.
- Juby, H. L., & Concepción, W. R. (2005). Ethnicity: The term and its meaning. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counselling, Vol. 1. Theory and research* (p. 26–40). John Wiley & Sons Inc.
- Kang, K.K. and Moran, N. (2020) Experiences of inpatient staff meeting the religious and cultural needs of BAME informal patients and patients detained under the Mental Health Act 1983, *Mental Health Review Journal*, Vol. 25, No.2, pp.113-125. [online] Available at: <https://doi.org/10.1108/MHRJ-11-2019-0041> [Accessed] 20 May 2024.
- Kapadia, D, Zhang, J, Salway, S, Nazroo, J, Booth, A, Villarroel-Williams, N, Becares, L & Esmail, A (2022), *Ethnic Inequalities in Healthcare: A Rapid Review*. NHS Race & Health Observatory. [online]available at: https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf [Accessed 11 Mar 2023]
- Kaplan, J.B., Bennett, T. (2003). Use of Race and Ethnicity in Biomedical Publication. *JAMA* 289(20):2709–2716. [online] Available at: <https://jamanetwork.com/journals/jama/article-abstract/196632> [Accessed 30 Mar 2020].
- Karban, K., Sparkes, T., Benson, S., Kilyon, J., Lawrence, J. (2021). Accounting for Social Perspectives: An Exploratory Study of Approved Mental Health Professional Practice, *The British Journal of Social Work*, Volume 51, Issue 1, Pages 187–204, <https://doi.org/10.1093/bjsw/bcaa037>
- Karger, H.J. & Hernandez, M. T. (2004). The decline of the public intellectual in social work. *Journal of Sociology and Social Welfare*, 31 (3), 51-68.
- Karlsen, S. (2002). Ethnicity, Environment and Health: Putting Ethnic Inequalities in Health in their Place. *Social Science & Medicine*. 55 (9), 1647.
- Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among Ethnic Minority groups in England. *Psychological medicine*, 35(12), 1795-1803.
- Kearney G.P., Corman M.K., Gormley G.J., Hart N.D., Johnston J.L., Smith D.E. (2018). Institutional Ethnography: a sociology of discovery—In conversation with Dorothy Smith. *Soc Theory Health* 16:292–306
- Kearney, G.P., Corman, M.K., Hart, N.D. (2019) Why institutional ethnography? Why now? Institutional ethnography in health professions education. *Perspect Med Educ* 8:17–24
- Keating, F., Robertson, D., McCulloch, A., Francis, E., (2002). *Breaking the Circles of Fear*. [online] The Sainsbury Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf [Accessed 20 Aug. 2023].

- Keating, F. (2016) 'Racialised Communities, Producing Madness and Dangerousness'. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Policy, and Practice* 5 (3), 1-13.
- Keating, F. and Southby, K. and Joseph, S. and Fisher, P. (2019) Socially oriented approaches to recovery for African and Caribbean men. Project Report. NIHR School for Social Care Research.
- Kelle, U., Prein, G. & Bird, K. (Eds.) (1995) *Computer-aided qualitative data analysis: theory, methods and practice*. London: Sage.
- Kenway, P., and Palmer, G. (2007). *Poverty among ethnic groups how and why does it differ?* [online] Available at: <http://www.poverty.org.uk/wp-content/uploads/2018/09/ethnicity.pdf> [Accessed Aug. 2021].
- Khunti K., Routen A., Pareek M. (2020) The language of ethnicity. *BMJ* 371: m4493.
- Kiernan, K. E., & Mensah, F. K. (2011). Poverty, family resources and children's early educational attainment: The mediating role of parenting. *British Educational Research Journal*, 37(2), 317–336. <https://doi.org/10.1080/01411921003596911>
- King, N & Brooks, J. (2017). *Template Analysis for Business and Management Students*. Mastering Business Research Methods, Sage Publications Ltd.
- Kinney, M. (2009). Being Assessed under the Mental Health Act – Can it Ever Be Ethical? *Ethics and Social Welfare* 3 (3): 329-336. doi:10.1080/17496530903209584.
- Kirkbride, J.B., Fearon, P., Morgan, C., Dazzan, P., Morgan, K., Tarrant, J., Lloyd, T., Holloway, J., Hutchinson, G., Leff, J.P., Mallett, R.M., Harrison, G.L., Murray, R.M. & Jones, P.B. (2006). Heterogeneity in incidence rates of schizophrenia and other psychotic syndromes - Findings from the 3-center AESOP study. *Archives of General Psychiatry*; 63:250-258.
- Knott, G. and Bannigan, K. (2013). A critical review of the approved mental health professional role and occupational therapy. *British Journal of Occupational Therapy*, 76(3), pp.118-126.
- Kovandzic M., Chew-Graham C., Reeve J., Edwards S., Peters S., Edge D., Aseem S., Gask L. Dowrick C. (2011): Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. *Social Science and Medicine* 72, 763–772. [online] Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21272968> [Accessed 22 Dec. 2019].
- Krefting, L (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *Am J Occup Ther* 1991;45(3):214–222. <https://doi.org/10.5014/ajot.45.3.214>
- Kvale, S. (1996). *Interview Views: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage Publications.
- Kyriakides, C, and Virdee, S. (2003). Migrant labour: Racism and the British National Health Service. *Ethnicity and Health*, 8(4), 283- 305. [online] Available at: <https://doi.org/10.1080/13557850310001631731> [Accessed 20 Jan 2020].
- Lacey, K. K., Powell Sears, K., Crawford, T. V., Matusko, N., & Jackson, J. S. (2016). Relationship of social and economic factors to mental disorders among population-based samples of Jamaicans and Guyanese. *BMJ open*, 6(12), e012870.[online] available at: <https://doi.org/10.1136/bmjopen-2016-012870> [Accessed 20 Jan 2020].

Laing, R. D., & Esterson, A. (1964). *Sanity, madness and the family*. Tavistock.

Lammy, D (2017) *The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System*. London: Lammy Review.
National Audit Office (2016) *Transforming Rehabilitation*.

Lashley, H. (1986). Prospects and problems of Afro-Caribbeans in the British education system. In C. Brock (Ed.). *The Caribbean in Europe: Aspects of the West Indian Experience in Britain, France, and The Netherlands* (pp. 137-165). London: Frank

Laurence, J. (2015). Community disadvantage and race-specific rates of violent crime: an investigation into the “racial invariance” hypothesis in the United Kingdom. *Deviant Behaviour*, 36(12), 974-995.

Lawlor C., Johnson S., Cole L., Howard L.M., (2012) Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *Int J Soc Psychiatry* 58(1): 3–15.

Lay, K. (2023). Thousands ‘will be betrayed’ if mental health reforms ditched. *The Times*. [online] 22 Aug. Available at: <https://www.thetimes.co.uk/article/thousands-will-be-betrayed-if-mental-health-reforms-ditched-gvlbnc0zp> [Accessed 22 Aug. 2023].

Lazard, L., & McAvoy, J. (2020). Doing reflexivity in psychological research: What’s the point? What’s the practice? *Qualitative Research in Psychology*, 17(2), 159–177. <https://doi.org/10.1080/14780887.2017.1400144>

Leah, C. (2022) The Role of the Approved Mental Health Professional: A ‘Fool’s Errand’? *The British Journal of Social Work*, Volume 52, Issue 7, Pages 3802–3819, <https://doi.org/10.1093/bjsw/bcac059>

Lebenbaum, M., Laporte, A. and de Oliveira, C., (2021). The effect of mental health on social capital: An instrumental variable analysis. *Social Science & Medicine*, 272, p.113693.

Leeming, D. (2018) The use of theory in qualitative research. *Journal of Human Lactation*, 34 (4), 668-673. [online] available at: https://pure.hud.ac.uk/ws/portalfiles/portal/14659077/About_research_JHL_DL_with_refs_.pdf [accessed 13 May 2020]

Legislation.gov.uk (2007). *Mental Health Act 2007*. [online] Legislation.gov.uk. Available at: <https://www.legislation.gov.uk/ukpga/2007/12/section/18> [Accessed 5 Dec. 2022].

Legislation.gov.uk. (2020). *Mental Health Act 1983*. [Online] Available at: <http://www.legislation.gov.uk/ukpga/1983/20/contents> [Accessed 2 Mar. 2020].

Legislation.gov.uk (2022). *Commonwealth Immigrants Act 1962*. [online] Legislation.gov.uk. Available at: <https://www.legislation.gov.uk/ukpga/1962/21/enacted> [Accessed 1 Aug. 2022].

Lewis, G., Croft-Jeffreys, C. & David, A. (1990) Are British psychiatrists racist? *British Journal of Psychiatry*, 157, 410–415.

Lincoln, Y.S., Guba, E.G. (1985). *Naturalistic inquiry*. London: Sage

Lingayah, S, Blackmore, E, and Sanderson, B (2020). *Common Ground Contested Space – Public and campaigner thinking about racism and what this means for building public support for racial justice*. Runnymede.

- Littell, J. H., & White, H. (2018). The Campbell Collaboration: Providing Better Evidence for a Better World. *Research on Social Work Practice*, 28(1), 6–12.
- Littlewood, R. (1988). Community-initiated research: A study of psychiatrists' conceptualisations of 'cannabis psychosis'. *Psychiatric Bulletin*, 12(11), 486-488. doi:10.1192/pb.12.11.486
- Littlewood, R. and Cross, S. (1980), Ethnic Minorities and Psychiatric Services. *Sociology of Health & Illness*, 2: 194-201. <https://doi.org/10.1111/1467-9566.ep10487792>.
- Longres, J. & Scanlon, E. (2001). Social justice and the research curriculum. *Journal of Social Work Education*, 37(3), 447-464 <https://doi.org/10.1080/10437797.2001.10779067>
- Louden, D.M. (1995). The epidemiology of schizophrenia among Caribbean-born and first- and second-generation migrants in Britain. *J Soc Distress Homeless* 4, 237–253. <https://doi.org/10.1007/BF02088020>
- Luanaigh, C.Ó. and Lawlor, B.A. (2008). Loneliness and the health of older people. *International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences*, 23(12), pp.1213-1221.
- Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in Qualitative Research: Rationale, Issues, and Methods. *Research on Aging*, 17(1), 89–113.
- Lune, H., & Berg, B. L. (2016). *Qualitative research methods for the social sciences*: Pearson Higher Ed.
- MacLeod, H. and Stadnyk, R.L. (2015). Risk: 'I know it when I see it': how health and social practitioners defined and evaluated living at risk among community-dwelling older adults. *Health, Risk & Society*, 17(1), pp.46-63.
- Macpherson (1999). *The Stephen Lawrence Inquiry*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/the-stephen-lawrence-inquiry> [Accessed 20 Aug. 2023].
- Madison, D. (2020). *Critical Ethnography: Method, Ethics, and Performance*. Third Thousand Oaks, CA: SAGE Publications, Inc. Available at: <<https://doi.org/10.4135/9781071878965>> [Accessed 23 Aug 2022].
- Mahy, G.E., Mallett, R., Leff, J. and Bhugra, D. (1999). First-contact incidence rate of schizophrenia in Barbados. *The British Journal of Psychiatry*, 175(1), pp.28-33.
- Maina, I. W., Belton, T. D., Ginzberg, S., Singh, A., & Johnson, T. J. (2018). A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Social science & medicine* (1982), 199, 219–229. <https://doi.org/10.1016/j.socscimed.2017.05.009>
- Mallett, R., Leff, J., Bhugra, D. Pang, D., & Zhao, J.H. (2002) Social environment, ethnicity and schizophrenia: a case-control study. *Social Psychiatry and Psychiatric Epidemiology*, 37, 329-335.
- Mandara, J., Gaylord-Harden, N.K., Richards, M.H., and Ragsdale, B.L. (2009). The Effects of Changes in Racial Identity and Self-Esteem on Changes in African American Adolescents' Mental Health. *Child Development*, 80(6), pp.1660–1675. doi:<https://doi.org/10.1111/j.1467-8624.2009.01360.x>.
- Manktelow, R. (2002). The Experience and Practice of Approved Social Workers in Northern Ireland. *British Journal of Social Work*, 32(4), pp.443–461. doi:<https://doi.org/10.1093/bjsw/32.4.443>.

- Mann F., Fisher H.L., Major B., Lawrence J., Tapfumaneyi A., Joyce J., Hinton M.F., Johnson S. (2014) Ethnic variations in compulsory detention and hospital admission for psychosis across four UK Early Intervention Services. *BMC Psychiatry* 14(1): 256.
- Marmot, M., Allen, J., Boyce, T., Goldblatt, P., and Morrison, J., (2020). *Health Equity in England: The Marmot Review 10 Years on Executive Summary*. [online] Available at: https://www.health.org.uk/sites/default/files/2020-03/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_executive%20summary_web.pdf [Accessed Aug. 2021].
- Mason, D. (2000). *Race and ethnicity in modern Britain*. Oxford Univ. Press.
- Mauthner, N. S., & Doucet, A. (2003). Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis. *Sociology*, 37(3), 413-431. <https://doi.org/10.1177/00380385030373002> [Accessed 20 May 2024]
- Maxwell, J.A. (2012) *Qualitative Research Design: An Interactive Approach*. Sage Publications, Inc., Thousand Oaks, CA.
- May, T. (2011). *Social Research: Issues, Methods and Process*. 4th ed. Maidenhead, Berkshire: Open University Press.
- McGovern, D. and Cope, R.V. (1987). First psychiatric admission rates of first and second generation Afro Caribbeans. *Social psychiatry*, 22, pp.139-149.
- McGuire, T. G., Alegria, M., Cook, B. L., Wells, K. B., & Zaslavsky, A. M. (2006). Implementing the Institute of Medicine definition of disparities: an application to mental health care. *Health Services Research*, 41(5), 1979-2005.
- McIntosh, P. (1988). *White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences Through Work in Women's Studies*. Wellesley Centers for Women, pp.1-17. [online] Available at: https://www.wcwonline.org/images/pdf/White_Privilege_and_Male_Privilege_Personal_Account-Peggy_McIntosh.pdf [Accessed 8 Aug. 2021].
- McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health care. *BMJ: British Medical Journal*, 334(7595), 649.
- McLean, C., Campbell, C., and Cornish, F., (2003) African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science and Medicine*, Vol 56, Issue 3, 2003; 657- 669.
- McPherson, K.E., Kerr, S., McGee, E., Morgan, A., Cheater, F.M., McLean, J. and Egan, J. (2014). The association between social capital and mental health and behavioural problems in children and adolescents: an integrative systematic review. *BMC psychology*, 2 (7).
- Memon, A., Mohebati, L.M., Collins, V., Campbell, M., Porter, A., Dale A., Hope, E., Koroma P., Ndebele, D. (2012), *A Qualitative Study of BME Mental Health and Wellbeing in Brighton and Hove*. [online] Available at: [Microsoft Word - Brighton and Hove BME MH study - June 2012 - Final.docx \(brighton-hove.gov.uk\)](https://www.brighton-hove.gov.uk/microsof-word-brighton-and-hove-bme-mh-study-june-2012-final.docx) [Accessed February 2020]

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., and de Visser, R. (2016). Perceived barriers to accessing mental health services among black and Minority Ethnic (BME) communities: a qualitative study in southeast England. *BMJ Open*, 6 (11). [Online] Available at: <http://bmjopen.bmj.com/content/6/11/e012337> [Accessed 22 Aug. 2019].

Mental Health Foundation (2012). *Employment Is Vital for Maintaining Good Mental Health*. [online] Mental Health Foundation. Available at: <https://www.mentalhealth.org.uk/blog/employment-vital-maintaining-good-mental-health> [Accessed 20 Aug. 2021].

Mental Health Network (2011). *Housing and Mental Health (Briefing 233): Innovation in housing, care and support | NHS Confederation*. [online] www.nhsconfed.org. Available at: [https://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Housing_MH_021211.pdf](https://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Housing_MH_021211.pdf) [Accessed 23 Aug. 2021].

Mgutshini T. (2010). Risk factors for psychiatric re-hospitalization: an exploration. *International journal of mental health nursing*, 19(4), 257–267. <https://doi.org/10.1111/j.1447-0349.2009.00664.x>

Mind, (2013a). *Mental Health Crisis Care: Commissioning Excellence for Black and Minority Ethnic Groups*. A briefing for Clinical Commissioning Groups. [online] Available at: <https://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf> [Accessed 2 Dec. 2019].

Mind (2013b). *Police and Mental Health - How to get it right locally*. Mind: London

Mind (2020). *Inequalities for Black Asian and Minority Ethnic communities in NHS mental health services in England*. [online] Available at: <https://www.mind.org.uk/media/6484/race-equality-briefing-final-oct-2020.pdf> [Accessed 1 Aug. 2021].

Ministry of Justice (2021). *Ethnicity and the Criminal Justice System, 2020*. [online] Gov.UK. Available at: <https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-statistics-2020/ethnicity-and-the-criminal-justice-system-2020> [Accessed 2 Aug. 2022].

Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S., & Beishon, S. (1997). *Ethnic minorities in Britain: Diversity and disadvantage*. London: Policy Studies Institute.

Møllersen, S. and Holte, A. (2008). Ethnicity as a variable in mental health research: A systematic review of articles published 1990–2004, *Nordic Journal of Psychiatry*, 62:4, 322–328, [online] available at: [10.1080/08039480802044414](https://doi.org/10.1080/08039480802044414) [Accessed 2 Dec. 2020].

Mompelat, L. (2019). Queer of colour hauntings in London's arts scene: performing disidentification and decolonising the gaze. A case study of the Cocoa Butter Club. *Feminist Theory*, 20(4), 445–463. <https://doi.org/10.1177/1464700119871850>

Monk Ellis, P. (2014). Skin Tone Stratification among Black Americans, 2001–2003. *Social Forces* 92(4):1313–37

Montgomery, J. D. (2000). Social Capital as a Policy Resource. *Policy Sciences*, 33(3/4), 227–243. <http://www.jstor.org/stable/4532502>, J. D. (2000). Social Capital as a Policy Resource. *Policy Sciences*, 33(3/4), 227–243.

Moren, S., & Blom, B. (2003). Explaining human change: On generative mechanisms in social work practice. *Journal of Critical Realism*, 2, 37–60.

Morgan C., Mallett R., Hutchinson G., Bagalkote H., Morgan K., Fearon P., Dazzan P., Boydell J., McKenzie K., Harrison G., (2005) Pathways to care and ethnicity. 1: sample characteristics and compulsory admission report from the ÆSOP study. *Br J Psychiatry* 186(4):281–289.

Morriss, L. (2016). AMHP Work: Dirty or Prestigious? Dirty Work Designations and the Approved MH Professional, *The British Journal of Social Work*, vol. 46, Issue 3, pp. 703–718. [Online] available at: <https://academic.oup.com/bjsw/article/46/3/703/1754040> [Accessed 8 Oct 2021].

Morse, J.M. (2000) Determining Sample Size. *Qualitative Health Research* ;10(1):3-5.

Mykhalovskiy, E. (2003). Evidence-Based Medicine: Ambivalent Reading and the Clinical Recontextualization of Science, *Health*, 7(3), pp. 331–352.

Mykhalovskiy, E. and McCoy, L. (2002) Troubling ruling discourses of health: Using institutional ethnography in community-based research, *Critical Public Health*, 12:1, 17-37.

Mykhalovskiy, E., Armstrong, P., Armstrong, H., Bourgeault, I., Choiniere, J., Lexchin, J., Peters, S. and White, J. (2008). Qualitative Research and the Politics of Knowledge in an Age of Evidence: Developing a research-based Practice of Immanent Critique. *Social Science & Medicine*, 67(1), pp.195–203. doi:<https://doi.org/10.1016/j.socscimed.2008.03.002>.

Nacro, (2017). *Race, mental Health and criminal Justice. Moving Forward*. [Online] available at: <https://www.nacro.org.uk/news/nacro-news/race-mental-health-criminal-justice-moving-forward/> [Accessed 10 Aug. 2020].

Nacro (2007). *Mental Health and Crime Briefing. Black Communities mental health and the criminal justice system*. [online] Available at: <http://www.ohrn.nhs.uk/resource/policy/Nacroblackcommunities.pdf> [Accessed 20 Aug. 2023].

National Mental Health Development Unit (2021). *Briefing 3 Work, Recovery and Inclusion: Employment Support for People in Contact with Secondary Mental Health Services*. [online] Available at: https://www.centreformentalhealth.org.uk/sites/default/files/briefing3_work_recovery_and_inclusion.pdf [Accessed 8 Aug. 2022].

Nazroo, J. (2003) The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *Am J Public Health*.93:277–84.

Nazroo, J.Y. (1997). *Ethnicity and mental health: findings from a National Community Survey*. London. Policy Studies Institute.

Nguyen, A. and Pendleton, M. (2020). *Recognizing Race in Language: Why We Capitalize ‘Black’ and ‘White’*. [online] CSSP. Available at: <https://cssp.org/2020/03/recognizing-race-in-language-why-we-capitalize-black-and-white/> [Accessed 20 Jun. 2020].

NHS Digital (2022). *Mental Health Act Statistics, Annual Figures, 2021-22*. [online] NHS Digital. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2021-22-annual-figures> [Accessed 20 Aug. 2023].

NHS England, (2016). *The Five-Year Forward View for Mental Health*. A report from the independent Mental Health Taskforce to the NHS in England. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> [Accessed 22 Nov. 2020].

NHS England (2016). *The Five Year Forward View for Mental Health*. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> [Accessed 20 Aug. 2023].

Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003). *Independent Inquiry into the death of David Bennett*. Cambridge: Norfolk, Suffolk and Cambridgeshire SHA. [Online] Available at: https://www.blink.org.uk/docs/David_Bennett_report.pdf [Accessed 22 Aug. 2020].

Nyqvist F, et al. (2008) The effect of social capital on health: the case of two language groups in Finland. *Health Place*;14(2):347–360.

O'Brien, M. (2010). *Social justice: Alive and well (partly) in social work practice*. *International Social Work*, 54(2), 174–190. <https://doi.org/10.1177/0020872810382682>

Office For National Statistics (2022). *2021 Census analysis: Ethnicity and religion of the non-UK born population in England and Wales - Office for National Statistics*. [online] Ons.gov.uk. Available at: [Ethnic group, England and Wales - Office for National Statistics \(ons.gov.uk\)](#) [Accessed 23 May 2024].

Office of National Statistics (ONS) (2020). *Homicide in England and Wales - Office for National Statistics*. [online] www.ons.gov.uk. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019#:~:text=There%20were%20671%20victims%20of> [Accessed 2 Dec. 2020].

Office of National Statistics (ONS) (2021). *Employment in the UK: May 2021*. [online] Ons.gov.uk. Available at: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/latest> [Accessed 20 Jan. 2022].

Office of National Statistics (ONS) (2022). *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England - Office for National Statistics*. [online] www.ons.gov.uk. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronavirusCOVID19englandandwales/8december2020to1december2021> [Accessed 2 Dec. 2022].

O'Hare, P., Davidson, G., Campbell, J. and Maas-Lowit, M. (2013). Implementing Mental Health Law: A Comparison of Social Work Practice Across Three Jurisdictions. *The Journal of Mental Health Training, Education and Practice* 8 (4): 196- 207. doi:10.1108/JMHTEP-12-2012-0044.

Okolosie, L., Harker, J., Green, L. and Dabiri, E. (2015). Is it time to ditch the term 'Black, Asian and Minority Ethnic' (BAME)? *The Guardian*. [online] 22 May 2015. Available at: <https://www.theguardian.com/commentisfree/2015/may/22/black-asian-minority-ethnic-bame-bme-trevor-phillips-racial-minorities> [Accessed March 25. 2020].

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, 42, 371–387 <https://doi.org/10.1093/bjsw/bcr064> [Accessed 20 May 2023]

Palmer D., Caldas B. (2015) Critical Ethnography. In: King K., Lai YJ., May S. (eds) *Research Methods in Language and Education. Encyclopedia of Language and Education* (3rd ed.). Springer, Cham https://doi.org/10.1007/978-3-319-02329-8_28-1

Parris, M. (2016). 'BME' Is Racist and Misleading. Let's Drop It. *The Times*, 6 February 2016 [online] Available at: <https://www.thetimes.co.uk/article/bme-is-racist-and-misleading-lets-drop-it-d3q87mxj9zz> [Accessed 22 April 2020].

- Parton, N. & O'Byrne, P. (2000). *Constructive Social Work: Towards a New Practice*. Red Globe Press.
- Paterson M, Higgs J, Wilcox S. (2005). The Artistry of Judgement: A Model for Occupational Therapy Practice. *British Journal of Occupational Therapy*. 68(9):409-417. doi:10.1177/030802260506800905
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. 3rd ed Sage Publications; Thousand Oaks, CA.
- Paul, K. (1997). *Whitewashing Britain: Race and Citizenship in the Postwar Era*. Ithaca: Cornell University Press.
- Peay, J. (2003). *Decisions and Dilemmas: Working with Mental Health Law*. Oxford: Hart.
- Peirce, B. (1995). The theory of methodology in qualitative research. *TESOL Quarterly*, 29(3), 569-576.
- Pence, E. (2001). Safety for Battered Women in a Textually Mediated Legal System. *Culture and Organization*. 7. pp 199-229.
- Pence, E. (1997). *Safety for battered women in a textually mediated legal system*. (Doctoral dissertation), University of Toronto, Toronto.
- Pereira, S., Sarsam, S., Bhui K., & Paton, C. (2006). The London Survey of Psychiatric Intensive Care Units: psychiatric intensive care; patient characteristics and pathways for admission and discharge. *Journal of Psychiatric Intensive Care*, vol. 1, no. 1, pp. 17-24.
- Pinto, R., Ashworth, M., Jones, R. (2008). Schizophrenia in black Caribbeans living in the UK: an exploration of underlying causes of the high incidence rate. *Br J Gen Pract*. 58(551):429-34. doi: 10.3399/bjgp08X299254. PMID: 18505621; PMCID: PMC2418996.
- Pithouse, A. (1987.) *Social work: the social organisation of an invisible trade*, Aldershot, Avebury.
- Platt, L., & Warwick, R. (2020). *Are some ethnic groups more vulnerable to COVID-19 than others?* The Institute for Fiscal Studies.
- Polanco-Roman, L., Danies, A., & Anglin, D. M. (2016). Racial discrimination as race-based trauma, coping strategies, and dissociative symptoms among emerging adults. *Psychological trauma: Theory, research, practice and policy*, 8(5), 609–617. <https://doi.org/10.1037/tra0000125>
- Polanyi, M. (1983). *The Tacit Dimension*. Gloucester, MA: Peter Smith.
- Powell, A. (2019). *Unemployment by Ethnic Background, Briefing Paper 6385*. [online] p.6385. Available at: <https://researchbriefings.files.parliament.uk/documents/SN06385/SN06385.pdf> [Accessed 22 May 2019].
- Prins H. A. & Committee of Inquiry into The Death in Broadmoor Hospital of Orville Blackwood. (1993). *Report of the committee of inquiry into the death in Broadmoor hospital of Orville Blackwood and a review of the deaths of two other Afro-Caribbean patients: "Big Black and Dangerous?"*. London: SHSA
- Probst, B. and Berenson, L. (2014). The double arrow: How qualitative social work researchers use reflexivity. *Qualitative social work*, 13(6), pp.813-827.

- Prodinge, B. & Turner, S. (2013). Using institutional ethnography to explore how social politics infiltrate everyday life. *Journal of Occupational Science*, 20(4), 357-369.
- Prodinge B., Shaw L. & Laliberte Rudman D. (2013). Institutional ethnography: Studying the situated nature of occupation. *Journal of Occupational Science*, 22(1), 71-81
- Public Health England (2020). *Disparities in the risk and outcomes of COVID-19*. [online] Public Health England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf [Accessed 22 Aug. 2023].
- Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. Touchstone Books/Simon & Schuster. <https://doi.org/10.1145/358916.361990>
- Qassem, T., Bebbington, P., Spiers, N., McManus, S., Jenkins, R. and Dein, S. (2015). Prevalence of psychosis in black ethnic minorities in Britain: analysis based on three national surveys. *Social Psychiatry and Psychiatric Epidemiology*, [online] 50(7), pp.1057–1064. Available at: <https://link.springer.com/article/10.1007%2Fs00127-014-0960-7> [Accessed 20 Aug. 2023].
- QSR International Pty Ltd (2014). *NVivo qualitative data analysis Software*; Version 10.
- Quirk, A., Lelliott, P., Audini, B. and Buston, K. (2003). Non-clinical and extra- legal influences on decisions about compulsory admission to psychiatric hospital, *Journal of Mental Health*, 12(2), pp. 119-130. [Online] Available at: <https://doi.org/10.1080/0963823031000103434> [Accessed 2 March 2022].
- Rabiee, F. and Smith, P. (2013). Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. *Journal of Mental Health Promotion*, 15, 162-177.
- Rabiee, F., and Smith, P. (2014). Understanding mental health and experience of accessing services in African and African Caribbean users and carers in Birmingham UK. *Diversity and Equality in Health and Care*, 11, 125-134.
- Raleigh V.S., Irons R., Hawe E., Scobie S., Cook A., Reeves R., Petruckevitch A., Harrison J. (2007) Ethnic variations in the experiences of mental health service users in England. Results of a national patient survey programme. *Br J Psychiatry* 191(4): 304–312.
- Rankin, J. M. (2003), 'Patient satisfaction': knowledge for ruling hospital reform — An institutional ethnography. *Nursing Inquiry*, 10: 57-65.
- RAW.Org. (2010). *The end of delivering race equality? Perspectives of frontline workers and service users from racialised groups*. [Online] Available at: <https://www.mind.org.uk/media/273467/the-end-of-delivering-race-equality.pdf> [Accessed 22 July 2020].
- Rethink Mental Illness (2017). *A mental health act fit for tomorrow: an agenda for reform* [Online] Available at: <https://www.rethink.org/media/2854020/a-mental-health-act-fit-for-tomorrow.pdf> [Accessed 17 Aug. 2019].
- Richman, N. E., & Sokolove, R. L. (1992). The experience of aloneness, object representation, and evocative memory in borderline and neurotic patients. *Psychoanalytic Psychology*, 9(1), 77–91. <https://doi.org/10.1037/h0079323>

- Richter, D., Wall, A., Bruen, A. and Whittington, R. (2019). Is the global prevalence rate of adult mental illness increasing? Systematic review and meta-analysis. *Acta Psychiatrica Scandinavica* 140, 393–407
- Riessman, C. K. (2007). *Narrative Methods for the Human Sciences*, Thousand Oaks, CA, Sage
- Rodela, T.T., Tasnim, S., Mazumder, H., Faizah, F., Sultana, A. and Hossain, M.M. (2020). *Economic impacts of coronavirus disease (COVID-19) in developing countries*.
- Rogers, A. and Faulkner, A. (1987). *A Place of Safety*. MIND Publications.
- Rogers, J. P., Chesney, E., Oliver, D., Pollak, T. A., McGuire, P., Fusar-Poli, P., et al. (2020). Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. *Lancet Psychiatry* 7, 611–627. doi: 10.1016/S2215-0366(20)30203-0
- Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53: 304-310.
- Rothman, J. & Mizrahi, T., (2014). Balancing Micro and Macro Practice: A Challenge for Social Work, *Social Work*, Volume 59, Issue 1, January 2014, Pages 91-93, <https://doi.org/10.1093/sw/swt067>
- Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing (2nd ed.): The art of hearing data*. SAGE Publications, Inc., <https://doi.org/10.4135/9781452226651>.
- Runnymede (2021). *Sewell Reports: Runnymede Responds*. [online] www.runnymedetrust.org. Available at: <https://www.runnymedetrust.org/sewell> [Accessed 4 Feb. 2022].
- Salmons, J., (2016). *Doing Qualitative Research Online*. 55 City Road, London: SAGE Publications Ltd. Available at: <https://doi.org/10.4135/9781473921955> [Accessed 13 Mar 2023].
- Salway, S., Mir, G., Turner, D., Ellison, G.T.H., Carter, L. and Gerrish, K. (2016). Obstacles to ‘race equality’ in the English National Health Service: Insights from the healthcare commissioning arena. *Social Science & Medicine*, 152, pp.102–110. doi:<https://doi.org/10.1016/j.socscimed.2016.01.031>.
- Samovar, L., Porter, R., McDaniel, E. (2009). *Communication Between Cultures*. Wadsworth Cenage Learning: Wadsworth Boston USA.
- Sandhu, R. (2018). Should BAME be ditched as a term for black, Asian and Minority Ethnic people? *BBC News*, 17 May 2018. Available at: <https://www.bbc.co.uk/news/uk-politics-43831279> [Accessed 22 April 2020].
- Sashidharan, S. (2003). From outside to inside: Improving mental health services for Black and Minority Ethnic communities in England. *Mental Health Review Journal*, 8(3), 22-25.
- Sashidharan, S. P. (1990). *Subject: Psychiatry. Diagnosis: Racist*. Healthmatters, 17.
- Sashidharan, S.P. (2001). Institutional racism in British psychiatry. *Psychiatric Bulletin*, 25, 244-247.
- Sayer, A. (2010). *Method in social science*. (Rev.2nd ed.), Taylor & Francis e-library. Oxon: Routledge.

Scheffler, R.M., Brown, T.T., Rice, J.K. (2007) The role of social capital in reducing non-specific psychological distress: the importance of controlling for omitted variable bias. *Soc Sci Med.* ;65(4):842–854.

Schreiber, L.M. and Valle, B.E. (2013) Social Constructivist Teaching Strategies in the Small Group Classroom. *Small Group Research*, No. 2, 1-17. <https://doi.org/10.1177/1046496413488422> [Accessed 20 May 2024]

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9), 9-16.

Seale, C. (2017). *Researching Society and Culture*. 4. ed. Los Angeles, California: Sage Publications

Seidel, J. V. (1998). Qualitative Data Analysis. Originally Published as Qualitative Data Analysis, in the *Ethnograph v5.0: A Users Guide*, Appendix E, 1998, Colorado

Senior, P., Bhopal, A. (1994). Ethnicity as a variable in epidemiological research *BMJ* 309:327. [Online] available at: <https://doi.org/10.1136/bmj.309.6950.327> [Accessed 30 Mar. 2020].

Serrant-Green L. (2002). Black on black: methodological issues for black researchers working in Minority Ethnic communities. *Nurse researcher*, 9(4), 30–44. <https://doi.org/10.7748/nr2002.07.9.4.30.c6196>

Sewell, H. (2012). Race and ethnicity in mental health care. In P. Phillips, T. Sandford, and C. Johnston (Eds.) *Working in mental health: Policy and practice in a changing environment*. Oxon: Routledge pp. 104 -115.

Sexton-Roy, C., McDaniel, E.R., Samovar, L.A. and Porter, R.E. (2017). *Communication Between Cultures*. Wadsworth: Cengage Learning.

Shankley, W., and Williams, P. (2020). 3: Minority Ethnic groups, policing and the criminal justice system in Britain. In *Ethnicity, Race and Inequality in the UK*, Bristol, UK: Policy Press. [online] available at: < <https://doi.org/10.51952/9781447351269.ch003>> [Accessed 23 August 2021]

Sharland, E. (2012). Systematic Review. In: M. Gray, J. Midgely, and S. Webb (eds). *Handbook of Social Work*. pp.482-489. London: Sage.

Sharpe, J., & Shafe, S. (2016). Mental Health in the Caribbean. In J. L. Roopnarine & D. Chadee (Eds.), *Caribbean psychology: Indigenous contributions to a global discipline* (pp. 305–325). American Psychological Association. [online] available at: <https://doi.org/10.1037/14753-013> [Accessed 23 August 2021]

Shaw, I. (1999). *Qualitative Evaluation*. London: Sage.

Shaw, I., Orme, J., Briar-Lawson, K. (2009). *The SAGE Handbook of Social Work Research*. London: Sage.

Sheppard, M. (1990). *Mental Health: The Role of the Approved Social Worker*. Sheffield: Joint Unit for Social Services Research.

- Sheppard, M. (1993). Theory for Approved Social Work: The Use of the Compulsory Admissions Assessment Schedule. *British Journal of Social Work* 23 (3): 231-257.
doi:10.1093/oxfordjournals.bjsw.a055973
- Sheppard, M. (2000). Reflexivity and the development of process knowledge in social work: a classification and empirical study, *The British Journal of Social Work*, Volume 30, Issue 4, Pages 465–488, <https://doi.org/10.1093/bjsw/30.4.465>
- Shiner, M., Carre, Z., Delsol, R. and Eastwood, N. (2018). *The Colour of Injustice: 'Race', drugs and law enforcement in England and Wales*. [online] Available at: <https://www.lse.ac.uk/united-states/Assets/Documents/The-Colour-of-Injustice.pdf> [Accessed 22 May 2019].
- Siegel, S., Alderwick, H., Vuik, S., Ham, C. and Patel, H., (2016). Healthy Populations Designing Strategies to Improve Population Health. Report of the WISH Healthy Populations Forum.
- Simpson, M. (2020). A structured narrative literature review of approved mental health professional detention decisions: An infusion of morality. *Practice*, 32(4), pp.285-300.
- Sinding, C. (2010). Using institutional ethnography to understand the production of health care disparities. *Qualitative Health Research*, 20, 1656-1663. [Online] available at: <https://doi.org/10.1177%2F1049732310377452> [Accessed 30 Mar 2020].
- Singh, S. P., & Burns, T. (2006). Race and mental health: there is more to race than racism. *BMJ*, 333(7569), 648-651.
- Singh S.P., Burns, T., Tyrer, P., Islam, Z., Parsons, H., Crawford, M. (2014) Ethnicity as a predictor of detention under the Mental Health Act. *Psychol Med* 44(05):997–1004.
- Singh S.P., Croudace T., Beck A., Harrison G., (1997) Perceived ethnicity and the risk of compulsory admission. *Soc Psychiatry Psychiatr Epidemiol* 33(1): 39–44.
- Singh, S. P., Greenwood, N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983. *The British journal of psychiatry: The journal of mental science*, 191, 99–105.
<https://doi.org/10.1192/bjp.bp.106.030346>
- Sirin, S. R. (2005). Socioeconomic status and academic achievement: *A meta-analytic review of research*. *Review of Educational Research*, 75(3), 417-453
- Skills for Care (2022). *Approved Mental Health Professional (AMHP) workforce*. [online] www.skillsforcare.org.uk. Available at: <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx> [Accessed 1 Dec. 2022].
- Skinner, L. (2006). *Negotiating Uncertainty: Mental Health Professionals' Experiences of the Mental Health Act Assessment Process*. DCLinPsych diss., University of Leicester
- Smith, T. E. (1981). *Commonwealth Migration: Flows and Policies*. Hong Kong: The MacMillan Press Ltd.
- Smith, D.E. (1987). *The everyday world as problematic: A feminist sociology*. Toronto, ON: University of Toronto.

- Smith, D. E. (1990). The ideological practice of sociology. *The conceptual practices of power: a feminist sociology of knowledge*. Toronto: University of Toronto Press.
- Smith, D. E. (1993). *Texts, facts, and femininity: exploring the relations of ruling*: Taylor & Francis.
- Smith, D. E. (1999). *Writing the Social: Critique, Theory, and Investigations*. University of Toronto Press. <http://www.jstor.org/stable/10.3138/9781442683747>.
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Toronto: AltaMira.
- Smith, D.E. (2006). *Institutional ethnography as practice*. Oxford: Rowman & Littlefield.
- Smith, G. W. (1990). Political activist as ethnographer. *Social Problems*, 37, 629-648
- Snow, N. (2015). *Exploring community treatment orders: An institutional ethnographic study* (Doctoral dissertation). University of Alberta, Canada.
- Social Exclusion Unit (2004). Mental Health and Social Exclusion. *Social Exclusion Unit Report*, London: Office of the Deputy Prime Minister.
- Social Metrics Commission (SMC) (2020). *Measuring Poverty 2020*. [online] Available at: <https://socialmetricscommission.org.uk/wp-content/uploads/2020/06/Measuring-Poverty-2020-Web.pdf> [Accessed 23 Aug. 2021].
- Social Perspectives Network (SPN) (2022). *SPN*. [online] SPN. Available at: <https://www.spn.org.uk/> [Accessed 24 Aug. 2023].
- Social Work England (2019). *Professional Standards*. [online] Social Work England. Available at: <https://www.socialworkengland.org.uk/standards/professional-standards/> [Accessed 21 Aug. 2023].
- Solomos, J. (2003). *Race and Racism in Britain (3rd edition)*. NY: Palgrave Mac.
- Stone, K. (2017). *Decisions on Risk and Mental Health Hospital Admission by Approved Mental Health Professionals*. DSocSci diss., University of Bristol.
- Stone, K. (2019). *Approved Mental Health Professionals and Detention: An Exploration of Professional Differences and Similarities, Practice*, 31:2, 83-96, DOI: 10.1080/09503153.2018.1445709
- Stone, K. and Spencer-lane, T. (2020). *The Approved Mental Health Professional Practice Handbook*. Bristol: Policy Press.
- Strand, S. (1999). Ethnic group, sex and economic disadvantage: Associations with pupils' educational progress from Baseline to the end of Key Stage 1. *British Educational Research Journal*, 25, (2), 179-202.
- Strand, S. (2010). Do some schools narrow the gap? Differential school effectiveness by ethnicity, gender, poverty and prior attainment. *School Effectiveness and School Improvement*, 21(3), 289-314.
- Strand, S. (2011). The limits of social class in explaining ethnic gaps in educational attainment. *British Educational Research Journal*, 37(2), 197-229

- Strand, S. (2014). Ethnicity, gender, social class and achievement gaps at age 16: Intersectionality and 'Getting it' for the white working class. *Research Papers in Education*, 29, (2), 131-171. <http://dx.doi.org/10.1080/02671522.2013.767370>
- Strand, S. & J. Winston (2008). *Educational aspirations in inner city schools*. *Educational Studies* 34(4): 249-267
- Strang, A. & Quinn, N. (2014) *Integration or isolation? Mapping social connections and well-being amongst refugees in Glasgow*. Queen Margaret University.
- Sue D.W., Capodilupo C.M., Torino G.C., Bucceri J.M., Holder A., Nadal K.L., Esquilin M. Racial (2007) microaggressions in everyday life: implications for clinical practice. *American Psychologist*. 62(4):271–286.
- Sutherland, M. (2006). African Caribbean Immigrants in The United Kingdom: The Legacy of Racial Disadvantages. *Caribbean Quarterly*, 52(1), 26-52. [online] Available at: <http://www.jstor.org/stable/40654533> [Accessed 20 Jan 2020]
- Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: values and costs. *Behavioral sciences & the law*, 31 1, 125-40.
- Tanenbaum, S. J. (1994). Knowing and acting in medical practice: The epistemological politics of outcomes research. *Journal of Health Politics, Policy and Law*, 19(1), 27– 44.
- Tarback, P., Topping-Morris, B., and Burnard, P. (1999). *Forensic mental health nursing: Policy, strategy and implementation*. London, England: Whurr Publications.
- Taylor, E. (2010). The Bradley Report and the Government's Response: The implications for mental health services for offenders. *Probation Journal*, 57(3), 330–332. <https://doi.org/10.1177/02645505100570030906>
- Tew, J. (2011), *Social Approaches to Mental Distress*. Palgrave Macmillan.
- Tew, J. (ed) (2005). *Social perspectives in mental health*. Jessica Kingsley Press.
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *The British Journal of Social Work*, 42(3), 443–460. <http://www.jstor.org/stable/43771654>
- The Prison Reform Trust. (2017). *Counted Out: Black, Asian and Minority Ethnic women in the criminal justice system*. London: Prison Reform Trust.
- The Schizophrenia Commission (2012). *The abandoned illness A report by the Schizophrenia Commission Executive Summary*. [online] Available at: https://www.rethink.org/media/2629/the-abandoned-illness_tsc_executive_summary_14_nov.pdf [Accessed 20 Aug. 2023].
- Thomas, J. (1993). *Doing Critical Ethnography*. Qualitative Research Methods. Newbury Park, CA: SAGE Publications, Inc. Available at: <https://doi.org/10.4135/9781412983945> [Accessed 23 Aug 2021].
- Thompson, P. (1997). Approved Social Work and Psychotherapy. *Practice* 9 (2) 35-46. doi:10.1080/09503159708411645

- Thompson, P. (2003). Devils and Deep Blue Seas: The Social Worker In-Between. *Journal of Social Work Practice* 17 (1): 35-47. doi:10.1080/0265053032000071466.
- Thompson, J., & Collier, M. J. (2006). Toward contingent understandings of intersecting identifications among selected US interracial couples: Integrating interpretive and critical views. *Communication Quarterly*, 54(4), 487–506. doi:10.1080/01463370601036671
- Thornicroft G. (1991). Social deprivation and rates of treated mental disorder. Developing statistical models to predict psychiatric service utilisation. *The British journal of psychiatry: The journal of mental science*, 158, 475–484. <https://doi.org/10.1192/bjp.158.4.475>
- Thornicroft, G. and Szmukler, G. (Eds.) (2001). *Textbook of Community Psychiatry*. Oxford: OUP.
- Timimi S.B. (2005). Racism in psychiatry. Author's reply. *British Journal of Psychiatry*, 186, 540-540.
- Tolmac J., Hodes M., (2004) Ethnic variation among adolescent psychiatric in-patients with psychotic disorders. *Br J Psychiatry* 184(5): 428–431.
- Townsend, E. (1996). Institutional ethnography: A method for showing the context shapes practice. *The Occupational Therapy Journal of Research*, 16(3), 179-199.
- Trevithick, P. (2008). Revisiting the knowledge base of social work: A framework for practice. *British Journal of Social Work*, 38, 1212-1237. doi:10.1093/bjsw/bcm026
- Troyna, B. (1995). Beyond Reasonable Doubt? Researching “Race” in Educational Settings. *Oxford Review of Education*, 21(4), 395–408. <http://www.jstor.org/stable/1050718>
- Turner, K., Moran, N.E., Moretti, A. & Hughes, N. (2021), *Embedding mental health support within district police stations*. N8 PRP. [online] Available at : <https://n8prp.org.uk/wp-content/uploads/2021/04/Embedding-MH-nurses-N8-4Page-Report-1.pdf> [Accessed] 20 May 2024.
- Tyler, K. M., Stevens-Watkins, D., Burris, J. L., Fisher, S. D., & Hargons, C. N. (2022). Black Psychology and Whiteness: Toward a Conceptual Model of Black Trauma through the Prism of Whiteness. *Journal of Black Psychology*, 48(1), 5–42.[online] Available at: <https://doi.org/10.1177/00957984211034948> [Accessed] 20 Dec 2022.
- UK Drug Policy Commission [UKDPC] (2010). *Drugs and Diversity: Ethnic Minority groups Learning from the evidence*. [online] Available at: [Policy report - Drugs and diversity ethnic minority groups \(policy briefing\).pdf \(ukdpc.org.uk\)](https://www.ukdpc.org.uk/wp-content/uploads/Policy-report-Drugs-and-diversity-ethnic-minority-groups-policy-briefing.pdf) [Accessed] 20 Dec 2022
- Wilson, J. P., Hugenberg, K., & Rule, N. O. (2017). Racial bias in judgments of physical size and formidability: From size to threat. *Journal of Personality and Social Psychology*, 113(1), 59–80. <https://doi.org/10.1037/pspi0000092>
- UK Drug Policy Commission [UKDPC] (2010). *Drugs and Diversity: Ethnic Minority groups Learning from the evidence*. [online] Available at: [https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Drugs%20and%20diversity_%20ethnic%20minority%20groups%20\(policy%20briefing\).pdf](https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Drugs%20and%20diversity_%20ethnic%20minority%20groups%20(policy%20briefing).pdf) [Accessed 3 Aug. 2021].
- UK Trauma Council (2022). *Trauma*. [online] UKTC. Available at: <https://uktraumacouncil.org/trauma/trauma?cn-reloaded=1> [Accessed 5 Aug. 2022].

- University of York (2018). *Research integrity and ethics* [online] available at: <https://www.york.ac.uk/staff/research/governance/research-integrity-and-ethics/> [Accessed 26 Dec. 2019]
- Van Ryn M. (2002). Research on the provider contribution to race/ethnicity disparities in medical care. *Medical care*, 40(1 Suppl), I140–I151. <https://doi.org/10.1097/00005650-200201001-00015>
- Vasileiou, K., Barnett, J., Thorpe, S.(2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Med Res Methodol* 18, 148 . <https://doi.org/10.1186/s12874-018-0594-7>
- Vicary, S. Young, A. and Hicks, S. (2019). Role Over’ or Roll Over? Dirty Work, Shift and Mental Health Act Assessments, *The British Journal of Social Work*, Volume 49, Issue 8, December 2019, Pages 2187–2206, <https://doi.org/10.1093/bjsw/bcz014>
- Villalonga-Olives, E., Wind, T.R., Armand, A.O., Yirefu, M., Smith, R. and Aldrich, D.P. (2022). Social-capital-based mental health interventions for refugees: a systematic review. *Social Science & Medicine*, 301, p.114787.
- Vinkers D, De Vries S, Van Baars A, Mulder, C. (2010). Ethnicity and dangerousness criteria for court ordered admission to a psychiatric hospital. *Soc Psychiatry Psychiatr Epidemiol* 45(2): 221–224.
- Walby, K. (2007). On the social relations of research: A critical assessment of institutional ethnography. *Qualitative Inquiry*, 13(7), 1008-1030. doi:10.1177/1077800407305809
- Wallace S., Nazroo J. & Becares, L. (2016). Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom. *American Journal of Public Health* 106(7), 1294-300.
- Wallace, M. and Wray, A. (2011). *Critical Reading and Writing for Postgraduates*. 2nd Edition. Thousand Oaks: Sage.
- Wall, S., Churchill, R., Hotopf, M., *et al* (1999). *A Systematic Review of Research Relating to the Mental Health Act (1983)*. London: Department of Health.
- Warner, J., & Gabe, J. (2004). Risk and Liminality in Mental Health Social Work. *Health, Risk & Society*, 6, 387-399.<http://dx.doi.org/10.1080/13698570412331323261>
- Watson, H., Harrop, D., Walton, E., Young, A. and Soltani, H. (2019). A Systematic Review of Ethnic Minority Women’s Experiences of Perinatal Mental Health Conditions and Services in Europe. *PLOS ONE* 14(1), pp.1–19, [online] available at: <https://doi.org/10.1371/journal.pone.0210587> [Accessed 4 Aug. 2021].
- Webber, M. and Huxley, P. (2004). Social Exclusion and Risk of Emergency Compulsory Admission. A Case-control Study, *Social Psychiatry and Psychiatric Epidemiology*, 39(12), pp. 1000-1009. [online] available at: <https://doi.org/10.1007/s00127-004-0836-3> [Accessed 5 Nov. 2020].
- Weinberg, M. (2002). Biting the hand that feeds you. In W. van den Hoonaard (Ed), *Walking the tightrope: Ethical issues for qualitative researchers* (pp. 79-94). Toronto: University of Toronto Press.
- West Midlands Police [WMP] (2020). *Predicting the Volume of Demand from Mental Health Related Police Incidents*. [online] Available at: <https://www.westmidlands-pcc.gov.uk/wp->

content/uploads/2021/02/14122020-EC-Agenda-Item-5c-Mental-Health-Deman-
Investigation.pdf?x39505 [Accessed 5 Aug. 2021].

Wharton, A.S. (2009) The Sociology of Emotional Labour. *Annual Review of Sociology*, 35 (1). pp. 147 - 165

White, A. (2002). *Social Focus in Brief: Ethnicity*, London: Office for National Statistics.

White, D.L., Delsol, R. and Shiner, M. (2020). Stop and Search: The Anatomy of a Police Power. *Policing: A Journal of Policy and Practice*, [online] 14(2). doi:<https://doi.org/10.1093/police/pax089>.

White, J., Nicholas S., and Maxim P. (2005). Impacts of Social Capital on Education Attainment in Aboriginal Communities: Lessons from Australia, Canada, and New Zealand. *Social Capital in Action: Thematic Policy Studies. Policy Research Initiative*.

White R, Bebbington P, Pearson J, Johnson S, Ellis D. (2000). The social context of insight in schizophrenia. *Soc Psychiatry Psychiatr Epidemiol.* 35(11):500–507. doi: 10.1007/s001270050271

Whitley R, McKenzie, K. (2005). Social capital and psychiatry: review of the literature. *Harv Rev Psychiatry*;13(2):71-84. doi: 10.1080/10673220590956474. PMID: 16020022.

Whitley, R., Prince, M., McKenzie, K., Stewart, R. (2006). Exploring the ethnic density effect: A qualitative study of a London electoral ward. *International Journal of Social Psychiatry*, 52, 376-391.

Wickersham, A., Nairi, S. Jones, R., Lloyd-Evans B. (2020). The Mental Health Act Assessment Process and Risk Factors for Compulsory Admission to Psychiatric Hospital: A Mixed Methods Study, *The British Journal of Social Work*, Volume 50, Issue 3, Pages 642- 663, <https://doi.org/10.1093/bjsw/bcz037>

Williams, J. (1986). *Education and race: The racialisation of class inequalities*. *British Journal of Sociology of Education*, 7(2), 135-154.

Williams, C., Alderson, P., & Farsides, B. (2002). Dilemmas encountered by health practitioners offering nuchal translucency screening: A qualitative case study. *Prenatal Diagnosis*, 22(3), 216– 220.

Williams D.R. (2018). Stress and the Mental Health of Populations of Colour: Advancing Our Understanding of Race-related Stressors. *Journal of Health and Social Behaviour*, 59(4), 466-485.

Williams D.R. & Williams-Morris R. (2000) Racism and mental health: the African American experience. *Ethnicity & Health*, 5(3-4), 243-68.

Williams, D.R., Mohammed, S.A. (2009). Discrimination and Racial Disparities in Health: Evidence and Needed Research. *Journal of Behavioural Medicine* 32(1):20–47. Retrieved January 1st, 2023 (<http://link.springer.com/10.1007/s10865-008-9185-0>).

Williamson, E.J., Walker, A.J., Bhaskaran, K. *et al.* (2020). Factors associated with COVID-19-related death using. *Nature* 584, 430–436 (2020). <https://doi.org/10.1038/s41586-020-2521-4>

Willig, C. (2013). *Introducing Qualitative Research in Psychology*. 3rd ed. Maidenhead: Open University Press.

Wilson, J. P., Hugenberg, K., & Rule, N. O. (2017). Racial bias in judgments of physical size and formidability: From size to threat. *Journal of Personality and Social Psychology*, *113*(1), 59–80. <https://doi.org/10.1037/pspi0000092>

Wolcott, F. (2009). *Writing Up Qualitative Research*. 3rd ed. Thousand Oaks, CA: Sage.

Wolcott, H. (1990). Making a study “more ethnographic.” *Journal of Contemporary Ethnography*, *19*(1), 44-72.

World Health Organisation (WHO) (2014). *Social Determinants of Mental Health*. [online] www.who.int. Available at: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf [Accessed 23 Aug. 2023].

Yin, R. K. (2018). *Case Study Research and Applications: Design and Methods* (6th ed.). Thousand Oaks, CA: Sage.

Zavaleta, D., Samuel, K., and Mills, C. (2014). “Social Isolation: A Conceptual and Measurement Proposal.” *OPHI Working Papers 67*, University of Oxford.

Appendices

Appendix A: Research ethics Committee (REC): Favourable ethical opinion letter



West Midlands - Coventry & Warwickshire Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

09 November 2020

Mrs Renée Aleong,
Chief Investigator
University of York
Department of Social Policy and Social Work
Heslington, York
YO10 5DD

Dear Mrs Renée Aleong,

Study title:	Approved Mental Health Professionals (AMHPs) and the compulsory detention of Black service-users under the Mental Health Act - An Institutional Ethnography
REC reference:	20/WM/0273
Protocol number:	N/A
IRAS project ID:	279345

The Research Ethics Committee reviewed the above application at the meeting held on 28 October 2020. Thank you for attending to discuss the application.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Number	Condition	Response from the applicant
1	<p>The REC identified that the following amendments should be made to the PIS:</p> <ul style="list-style-type: none">• Add text stating that if researchers observe any behaviour/actions that indicate risk to patients safety or their rights that this will be disclosed to the relevant authorities.• Add text clarifying that refusing to take part or withdrawing from participating in the research will have no impact on the staff's professional life.• Include the version number, document date and document title in the footer of the document.• Add text detailing how and when the interviews will take place.• Add text detailing that observations will take place in addition to the interviews and provide some information regarding what these observations will consist of and their purpose.	
<p>Recommendations</p> <p>In addition to the above condition to be addressed before the research begins, the committee also made the following recommendation to be issued to the applicants. Please note that a response to this point is not necessary for the research to begin, this only serves as additional guidance provided by the committee.</p> <ol style="list-style-type: none">1. The committee would like to emphasise that when remote interviews are being carried out by Zoom, please ensure that no video footage is captured during these interviews and only audio recordings are collected (in line with what is outlined in the ICF)		

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC

electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: <https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/>

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: <https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/>

You should notify the REC of the registration details. We routinely audit applications for compliance with these conditions.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: <https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/>

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: <https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/>

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at <https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/>.

Ethical review of research sites

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		14 September 2020
Letter from sponsor		14 September 2020
Other [Prof Martin Webber CV]	1.0	08 October 2020
Other [DR Jenny Threlfall CV]	1.0	08 October 2020
Participant consent form [Renee Aleong Participant Consent Form Sept 2020 V1.1]	V1.1	14 September 2020

Participant information sheet (PIS) [Renee Aleong Participant information sheet Sept 2020]	V1.1	14 September 2020
REC Application Form [SC_Form_08102020]		08 October 2020
Research protocol or project proposal [Renee Aleong IRAS Research Protocol V1]	V1	14 September 2020
Summary CV for Chief Investigator (CI) [Renee Aleong CV for IRAS Sept 2020]	V1	14 September 2020

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

IRAS project ID: 279345 Please quote this number on all correspondence
--

With the Committee's best wishes for the success of this project.

Yours sincerely



*p.p. Christopher Cole (Approvals Officer)
On behalf of the Chair*

**Dr Helen Brittain
Chair**

██

Enclosures: List of names and professions of members who were present at the

meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to:

Dr Michael Barber

Lead Nation: England (approvals@hra.nhs.uk)

West Midlands - Coventry & Warwickshire Research Ethics Committee

Attendance at Committee meeting on 28 October 2020

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Professor Jane Appleton	Nurse	No	
Dr Josephine Ashcroft	Retired Research Nurse	No	
Dr Helen Brittain	Clinical Psychologist Retired	Yes	
Ms Yasumati Damodar	Pharmacist	Yes	
Mrs Louise Harmer	Senior Medical Education Manager	Yes	
Dr Ronald Jubb	Retired Consultant Rheumatologist	Yes	
Dr Rebecca Keyte	Lecturer in Psychology	No	
Ms Sophie Krumins	Research Ethics and Integrity Manager	Yes	
Dr Aisha Malik	Senior Teaching Fellow at Warwick Medical School	No	
Dr Karen Schofield	Retired Consultant Haematologist	No	
Mrs Laura Strumidlo	Principal Lecturer Nursing	Yes	
Dr Thomas Edward Woodcock	Retired Consultant - Intensive Care Unit	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mr Chris Cole	Approvals Officer
Ms Amber Ecclestone	Approvals Specialist

Appendix B: Researcher response to REC conditions

10 November 2020

To: West Midlands – Coventry & Warwickshire Research Ethics Committee

Study title: Approved Mental Health Professionals (AMHPs) and the compulsory detention of Black service-users under the Mental Health Act - An Institutional Ethnography

IRAS project ID: 279345

REC reference: 20/WM/0273

Chief investigator: Renée Aleong, University of York, Department of Social Policy and Social Work, Heslington, York, YO10 5DD



Number	Condition	Response from applicant
1	<p>The REC identified that the following amendments should be made to the PIS:</p> <ul style="list-style-type: none">- Add text stating that if researchers observe any behaviour/actions that indicate risk to patients safety or their rights that this will be disclosed to the relevant authorities.- Add text clarifying that refusing to take part or withdrawing from participating in the research will have no impact on the staff's professional life.- Include the version number, document date and document title in the footer of the document.- Add text detailing how and when the interviews will take place.- Add text detailing that observations will take place in addition to the interviews and provide some information regarding what these observations will consist of and their purpose.	<p>The Chief Investigator has amended the participant information sheet (PIS) to include all conditions as set out by the REC. These changes have been highlighted within the revised PIS and submitted electronically through IRAS along with a revised version number and date.</p>

IRAS project ID 279345

REC ref 20/WM/0273

10/11/2020 V1



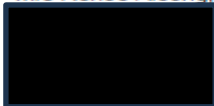
Appendix C: REC Compliance with approval conditions letter



West Midlands - Coventry & Warwickshire Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

10 November 2020

Mrs Renée Aleong



Dear Mrs Aleong

Study title: Approved Mental Health Professionals (AMHPs) and the compulsory detention of Black service-users under the Mental Health Act - An Institutional Ethnography
REC reference: 20/WM/0273
Protocol number: N/A
IRAS project ID: 279345

Thank you for your letter of response on the 10th of November 2020. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 09 November 2020

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Other [REC review applicant response 10 Nov 2020]	V1	10 November 2020
Participant information sheet (PIS) [Participant information sheet]	V2	10 November 2020

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only)		14 September 2020

Letter from sponsor		14 September 2020
Other [Prof Martin Webber CV]	1.0	08 October 2020
Other [DR Jenny Threlfall CV]	1.0	08 October 2020
Other [REC review applicant response 10 Nov 2020]	V1	10 November 2020
Participant consent form [Renee Aleong Participant Consent Form Sept 2020 V1.1]	V1.1	14 September 2020
Participant information sheet (PIS) [Participant information sheet]	V2	10 November 2020
REC Application Form [SC_Form_08102020]		08 October 2020
Research protocol or project proposal [Renee Aleong IRAS Research Protocol V1]	V1	14 September 2020
Response to Additional Conditions Met		
Summary CV for Chief Investigator (CI) [Renee Aleong CV for IRAS Sept 2020]	V1	14 September 2020

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 279345	Please quote this number on all correspondence
--------------------------------	---

Yours sincerely

Chris Cole

E-mail: coventryandwarwick.rec@hra.nhs.uk

Copy to: Mrs Renée Aleong,

Lead Nation: England (approvals@hra.nhs.uk)

Participant Information Sheet

Research title

Approved Mental Health Professionals (AMHPs) and the compulsory detention of Black service-users under the Mental Health Act - An institutional ethnography.

Who is undertaking the study?

My name is Renée Aleong. I am a registered social worker undertaking this research in support of my PhD in Social Policy and Social Work at the University of York. I would like to invite you to take part in this research study. Before you decide if you want to take part or not, I want to tell you why the research is being done, and what you can expect if you do take part. This information sheet explains the study. Please read this carefully. Take as much time as you like and mark anything you do not understand or want explained better. After you have read it, please ask questions about anything that is not clear.

What is the purpose of the study?

Research has consistently shown that people from Black ethnic groups are overrepresented within their local detained populations and are more likely to be detained under the Mental Health Act 1983 (MHA) than those in White groups. There are often varied explanations for these disparities, however, due to a lack of research in this area reasons remain speculative. This study aims to address this gap in knowledge by “mapping” the work processes of social worker AMHPs in order to understand how things happen the way they do. Mapping systemic processes may be useful in understanding how institutions, policies and procedures mediate AMHP work. The findings of this study will be useful to AMHPs, service-users, other professionals and policy makers within Britain’s mental health system, and may also provide much needed insight into the phenomena of overrepresentation of Black service-users.

Why have I been invited to take part?

You have been invited to take part in this study because you are currently a registered AMHP within a local authority’s workforce.

What does taking part involve?

If you choose to take part, you will be asked to sign a form, indicating that you consent to participate in this study. You will also be asked to provide some background information about yourself such as your age, gender, ethnicity and length of time as a practicing AMHP. This should take roughly 10 minutes to complete. You will then be asked to participate in an interview lasting up to 60 minutes, which will involve the following:

For AMHPs: I would like to ask you questions to understand your role in sectioning processes under the MHA and any experiences you may have had with Black or Ethnic Minority service-users (and/or their families) during this process; find out how your work is connected to other peoples' work – within your organisation or perhaps with other institutions/systems; see what kinds of policies, procedures, or processes guide your work (this may include looking at forms that you typically fill out).

For team leaders: I would like to ask you questions to help me understand what kinds of decisions and policies you are responsible for; how decisions or policies typically get made or changed and how they are informed; and any ideas or opinions you have on how the issue of overrepresentation of Black service-users is addressed within your team.

How and when interviews will take place?

I will endeavour to work with you to find a convenient time and place to interview you individually. Depending on your availability, an interview lasting up to 1 hour will be arranged to take place either face-to-face, via telephone or remotely via Zoom. Interviews will be arranged to take place in settings that protect your confidentiality and anonymity (e.g. interview room, office). Interviews will be audio recorded and transcribed by me in a private space. During transcription, any data that could potentially identify you will be anonymised or excluded from the transcription.

In addition to interviewing you, I will also observe you where possible to support information provided in the interview. Observations will consist of looking at forms that you typically fill out and any policies or procedures that guide your work. In some cases, I may request a follow up interview with you to get more depth and understanding about your work, as I learn more about the organisation. Follow up interviews should last up to 1 hour.

Do I have to take part?

Participation is voluntary and you can withdraw from the research at any time, without needing to provide a reason. Refusing to take part or withdrawing from participating in this research will have no impact on your professional life.

What are the benefits and risks of participating?

Given the nature of this study, it is highly unlikely that you will suffer harm by taking part. However, You can refuse to answer any questions that you feel uncomfortable with, or you can stop the interview anytime

I hope you will find the experience of taking part in the study interesting and useful. You will have the opportunity to receive a short report of the overall interview findings if you wish to.

Will I be identified in any research outputs?

The information collected during the study will only be used for research purposes and pseudonyms will be used to protect confidentiality and the identities of participants and service-users. No individual will be identifiable at any stage in the publication or presentation of the findings.

Confidentiality will be respected unless there are legitimate reasons for this to be breached. If I observe any behaviour/actions that indicate risk to patients or service-users' safety or their rights, this will be disclosed to the relevant authorities.

How will you keep my data secure?

Data collected as paper copies will be stored under lock and key, while the electronic data will only be accessed with a secure password through my personal filestore on the University of York's centrally managed network in accordance with the DPA 2018.

For how long will you keep my data?

In accordance with the University of York's Research Data Management Policy research data will be retained for 10 years from date of last requested access. Audio data will be destroyed at the end of the project.

Will you share my information with anyone else?

No. Details of names, personal addresses, postcodes, emails and telephone numbers of research participants would be destroyed after the end of the project. During the project, electronic and paper files will be stored securely, encrypted or password protected, and saved on the University of York's server. Further details are available in the separate 'Data information sheet' (see below).

What will happen to the results of the study? |

The results of the study may be used to inform the development of future practice-based interventions for the AMHP workforce. Additionally, the results may be published in formal reports and academic publications, such as conference papers or journals. All data collected will be anonymised, and it will not be possible to identify you from these results.

Who has given ethical approval to conduct the research?

The Coventry and Warwickshire Research Ethics Committee has given a favourable ethical opinion of this study.

Who is funding the study?

The study is supported by funding from the Economic and Social Research Council.

How do I find out more information?

I am happy to answer any questions about information in this package. And similarly, if you wish to take part, please email me, Renée Aleong [REDACTED] or mobile number [REDACTED]. If you do not wish to take part then you are not required to do anything and I will not contact you again.

How do I make a complaint?

In the first instance complaints should be directed to me, Renée Aleong, Chief Investigator of the research. If you are not satisfied, you may approach the University of York Department for Social Policy Social Work Ethics Committee using the email address: spsw-ethics@york.ac.uk. You may also approach my PhD supervisors Professor Martin Webber [REDACTED] and Dr Jenny Threlfall [REDACTED].

Data Information Sheet

Research Study: Approved Mental Health Professionals and the compulsory detention of Black service-users under the Mental Health Act - An institutional ethnography.

The purpose of this information sheet is to explain how your data will be used and protected, in line with General Data Protection Regulation (GDPR).

On what basis will you process my data?

The University of York is the sponsor of this research study and is also the data controller of the personal data of research participants processed for the purposes of this research. Under the GDPR, the University must identify a legal basis for processing personal data and, where appropriate, an additional condition for processing special category data.

In line with our charter, which states that we advance learning and knowledge by teaching and research, the University processes personal data for research purposes under Article 6 (1) (e) of the GDPR:

Processing is necessary for the performance of a task carried out in the public interest

Special category data is processed under Article 9 (2) (j):

Processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes

Research will only be undertaken where ethical approval has been obtained, where there is a clear public interest and where appropriate safeguards have been put in place to protect data.

In line with ethical expectations and to comply with common law duty of confidentiality, I will seek your consent to participate where appropriate. This consent will not, however, be my legal basis for processing your data under the GDPR.

How will you use my data?

Data will be processed for the purposes outlined in this notice and in the main information sheet. All interviews will be audio-recorded (with consent). The device used for audio-recording will be password protected; the audio file will be transferred to the secure University of York encrypted files server at the earliest opportunity and then deleted from the recording device. You will be required to provide informed consent for participation. This will include your signature. These consent forms will be scanned and kept on the researcher's drive on the secure University of York encrypted files server that only the researcher has access to. The anonymised findings will be analysed and a research paper submitted to the University and to a journal with the aim of publication. A summary of the findings will also be shared with participants on request.

How will you keep my data secure?

I will put in place appropriate technical and organisational measures to protect your personal data and/or special category data. For the purposes of this project I will ensure that all audio files and interview transcripts are password protected and saved onto the secure University of York fileserver.

The University is committed to the principle of data protection by design and default and I will collect the minimum amount of data necessary for the project.

Will you share my data with 3rd parties?

Data will only be accessible to my PhD supervisors, Professor Martin Webber and Dr Jenny Threlfall. We will request that other researchers have access to the anonymised transcript for future research, but you will have the opportunity to opt out of this at the consent stage.

Will I be identified in any research outputs?

You will not be identified in any research output. Names will not be used. Consent will be required for me to use direct quotes in publications, but these will be untraceable back to participants.

How long will you keep my data?

Data will be retained in line with legal requirements or where there is a business need. Retention timeframes will be determined in line with the University's Records Retention Schedule. Anonymised transcripts will be kept for ten years from the end of the study; consent forms will be kept for three years from the end of the study; audio recordings will be deleted at the end of the study.

What rights do I have in relation to my data?

Under the GDPR, you have a general right of access to your data, a right to rectification, erasure, restriction, objection or portability. You also have a right to withdrawal. Please note, not all rights apply where data is processed purely for research purposes. For further information see, <https://www.york.ac.uk/records-management/general-dataprotectionregulation/individualsrights/>

For this study, you have the right to withdraw your data up to two weeks after your interview has taken place.

Questions

If you have any questions about this participant information sheet or concerns about how your data is being processed, please contact Renee Aleong at [REDACTED]. If you are still dissatisfied, please contact the University's Data Protection Officer at [REDACTED].

If you are unhappy with the way in which the University has handled your personal data, you have a right to complain to the Information Commissioner's Office. For information on reporting a concern to the Information Commissioner's Office, see www.ico.org.uk/concerns.

Appendix E : Participant consent form

Department of Social Policy and Social Work



CONSENT FORM

Project title: Title: Approved Mental Health Professionals (AMHPs) and the compulsory detention of Black service-users under the Mental Health Act - An institutional Ethnography



		Please initial box
1	I confirm that I have read the information sheet dated..... for the above study. I have had the opportunity to consider the information and ask questions.	
2	I understand that I do not have to take part in the research. I am free to withdraw at any time without giving a reason.	
3	I will not be named in any research reports, and my personal information will remain confidential.	
4	I understand that if I inform the researcher that myself or someone else is at risk of harm they may have to report this to the relevant authorities – the researcher will discuss this with me first but may be required to report with or without my permission.	
5	I agree to be audio-recorded.	
6	I understand that my words, but not my name, may be used in research reports.	
7	I understand that I can withdraw permission to use data from my interview within 2 weeks after my interview, in which case the material will be deleted.	
8	I agree to take part in the research.	



Name of Participant:

Date:

Signature:

Name of researcher:

Date:

Signature:

For office info only.

Respondent ID

1

Version: consent_1.1

Appendix F: Introductory email to participants

Dear XXX,

Firstly, thank you for showing an interest in participating in my study. As you know, I am conducting interviews as part of my PhD research to increase my understanding of your role in sectioning processes under the Mental Health Act. As an AMHP, you are in an ideal position to give me valuable first-hand information from your own perspective.

The interview takes around 1 hour and is informal. I am simply trying to capture your thoughts and perspectives on the policies, procedures and processes, which guide your work. Your identity will be kept confidential and each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of findings.

There is no compensation for participating in this study. However, your participation will be a valuable addition to this research and findings could lead to a greater understanding of AMHP work and may also provide much needed insight into the phenomena of overrepresentation of Black service-users compulsory detained under the Mental Health Act.

If you are willing to participate, please suggest a day and time that suits you and I'll do my best to be available and will set up a virtual meeting via zoom. If you have any questions, please do not hesitate to ask. I have attached an information sheet with details of the study. I have also attached a consent form which you will need to sign and return to me before the interview. I look forward to hearing from you.

Best wishes

Renée

Renée Aleong
PhD Student University of York
Department of Social Policy and Social Work

Appendix G: Interview Schedule

[Before audio recording interview]

- Introduce myself
- Go through the participant information sheet verbally and ask if any questions
- Go through consent form, explain right to withdraw and check consent form is signed
- Go over areas I intend to cover
- Explain ethical exceptions/boundaries of confidentiality
- Explain channels of support within organisation
- Reiterate there's no right or wrong answer and that this is not a test etc.
- Ask if the participant has any further questions before starting

Prompts for additional information:

- What do you mean by that?
- Please, could you tell me a bit more about that?
- What was that like for you?
- How does that make you feel?
- How do you think about that?
- Can you give me an example?
- Tell me more

Check understanding by paraphrasing:

- Based on what you've told me it sounds like....is that right?

Areas to cover during debriefing:

- How did you find the interview?
- Do you have any further questions?
- You can email me if you think of questions after you leave
- Would you like a summary of the findings?

Field notes:

- Any notable themes?
- Social/organisational features of the setting.
- My reflections
- Any notable events during the interview (my behaviour or theirs)
- Context (historical, political, policy etc.)

Appendix H: Interview Guide

Broad questions through semi-structured interviews:

- Demographic data: gender, age, ethnicity?
- What is your job title? What area do you work in?
- What made you decide to take part in this research?
- How long have you been an AMHP?
- Can you describe your role? How does your role fit into current mental health services in England?
- How do you organise and prioritise what you do as an AMHP? Probe: Who makes those decisions?
- Talk me through the work processes involved in coordinating an MHA assessment and sectioning.
- What texts do you use in your work?
- Can you describe any challenges to your work?
- Is there anything I haven't covered that you would like to add?

Thinking of your work with Black service-users:

- Disproportionate sectioning of Black service users under S3 MHA -Why do you think this occurs?
- How are your actual frontline experiences of coordinating MHA assessments with Black service-users representative of the documented 'official' work you do? Are some things unaccounted for?
- When applying the least restrictive option and bringing the social perspective to bear on your decision, what factors influence your consideration of whether to detain an individual under the MHA? Are there specific implications for Black service-users?
- How do you bring the social perspective to bear on your decisions?
- What are the challenges (if any) of carrying out their role when conducting Mental Health Act (MHA) assessments with Black service-users?

- **Interdisciplinary working**
What is the role of interdisciplinary working when conducting MHA assessments with Black service-users? Can you talk me through the process? How is the work organised and coordinated?
- **Value of AMHP work**
Which aspects of their role offer the most and least value to Black service users?
- **Areas for improvement**
Which aspects of your role in working with Black service users need improving or expanding?
What do you think would be useful for your service to know about your experiences/observations of their commitment to addressing/tackling this issue?
- **Support**
What additional support could improve how AMHPs work with Black service users?

Appendix I: Excerpt of interview transcript

Interviewer: People from Black ethnic groups are disproportionately detained under section 3 of the Mental Health Act. What do you think are the reasons for this?

Participant 15: I want to think there's a lot of very interlinked reasons. Mistrust of services might lead people to avoid services and then things get so severe that some intervention is necessary. Obviously without the low-level interventions it's gone beyond that, and things have got really severe. And also, maybe just cultural beliefs and societal beliefs about mental health, about services, you know, different understandings of mental health.

Interviewer: Yes, yeah.

Participant 15: I think from services angle that there's obviously stereotypes about you know, big black men being a bit dangerous and scary so there's that aspect. There're misunderstandings of people's behaviour that can be misinterpreted, yeah you know if the person just behaves in a very effusive kind of way that might be just their normal manner, that's how they are.

Interviewer: Do you have any examples from your AMHP work when conducting Mental Health Act assessments with Black service-users? I'd be really interested to understand how you work through some of these things that you've told me about.

Participant 15: Yeah absolutely. There was a Nigerian woman who'd been referred by the community intensive support service as they felt that she was unwell and you know, lacking in insight to be treated in the community, so they recommended, they asked us to carry out a Mental Health Act assessment. Just by absolute good luck, one of the section 12 doctors was Nigerian. You know, they both were from the same area, same tribal background and so he was able to engage her in her first language and just chat with her. We, the doctor and I then sort of examined her beliefs talking in English so that obviously, I could understand and everything. We went through the things that she had been saying, and he (the doctor) actually was able to explain to me and the other doctor that these were really culturally fairly normal beliefs in you know, her culture. It just shed a whole different light on the situation, we were able to avoid bringing her into hospital, which was really important because she had a little boy with her. So, I sort of took him (the s.12 doctor) off and had a chat with him and he was very clear that he didn't feel she was at all in danger.

Appendix J: Transcripts with coding

Legend:

Talk- language informants use in their descriptions/understandings of how things happened

Texts and documents

Work – work of informants and their interactions with others/ insight into the work of others

People- whom informants interacted with directly or indirectly

Institutions – what organisations or agencies were referenced

Informant 7:

It was interesting to think when I look back at the assessments I've done and the people that I've seen as part of my job what's the proportion of people relative to population that I'm seeing are from minority backgrounds. Yeah, and in particular with CTOs (community treatment orders), it's younger Black men. I'm, seeing myself as part of that and just being really conscious. Yeah, you do when you're getting those referrals. Why this specific person? Are there any alternatives? Why am I seeing the same people over and over again?

Interviewer:

Tell me more about your experiences with services users from Black and Minority Ethnic backgrounds.

Informant 7:

People from minority backgrounds come into the system and end up having requests for things like CTOs relatively early in their experience with services as opposed to.... you might see people from different backgrounds who have been within services for a long time, presented with similar issues, similar experiences and haven't been considered for something like CTO so early. I'm not saying that that's necessarily you know, for any particular reason.

Interviewer:

Then why do you think that happens?

Informant 7:

I appreciate that more often than not people's intentions are good, they want to make sure that somebody stays well because they're young as well, they want them to have more chance of having a positive experience in life and more chance of recovery. But it is often a struggle with that because we've got a bit more of a you know, a draconian approach to supporting some... you know, we're enforcing things earlier, rather than giving people more chance to work with us as a service to improve their own mental health.

Interviewer:

Why do you think that's the case?

Informant 7:

I think a lot of it comes back to resource management, unfortunately, and it's a case of how can we keep people out of hospital, how we can stop people from needing to come back into acute services if we impose these things on them early. And...which is a much more medical model approach to working with people. I do think we have a real problem in XXXX with medical model approaches towards supporting people and particularly as resources dwindle that approach becomes more used. It's the limited resources we've gotten to keep people out of hospital.

Renee Aleong 30/10/2021 18:23

Comment [1]: This informant is consciously questioning the basis of some referrals and reflecting or "thinking back" on the proportion of young black men subjected to CTOs.

Renee Aleong 30/10/2021 18:27

Comment [2]: Informant acknowledges that from her experience people from minority backgrounds have differing interventions such as early requests for CTOs compared to other groups. Informant is not clear of reason for this.

Renee Aleong 30/10/2021 18:31

Comment [3]: This jumps out at me because the informant leaves room for speculation that some professionals may have intentions that are "not good". I was curious to explore the informants intentions with this comment.

Renee Aleong 30/10/2021 18:33

Comment [4]: This is an acknowledgement that by the informant that 'enforcement' is used in some cases as a means of getting service-users the appropriate medical intervention.

Renee Aleong 30/10/2021 18:34

Comment [5]: Again, informant talks about stopping people from needing acute services by "imposing these things on them".

Renee Aleong 30/10/2021 18:39

Comment [6]: Informant sees medical model approaches being relied on as lack of resources limits alternative interventions. Talks about the institution as "we" when referring to the problem of lack of resources.

Appendix K: Text and document analysis

I found it helpful to ask some explicit questions of texts, such as:

In what social circumstances and historical time did the text emerge?

What human experiences (if any) are included, and how are these shaped and discussed?

Who is the author?

What is the intended audience (readership)?

Are there any recurrent words or labels?

How is the text constructed, what is the shape of the narrative style?

What does the text intend to accomplish? Is this the same as the stated purpose of the text?

What work is referred to or implied? Who is doing this work?

Does the text have a sequence of work practices or actions? What bigger work processes does this localised work lead to?

How are these activities and practices coordinated?

What textual records are produced through documentary and other work forms?

Who uses this information and what purpose does it serve?

What can be said about ruling relations as written into text?

What is left unexplained or unaccounted for?

Appendix L: Refining emergent analytical themes

