Health, Risk & Society

ISSN: 1369-8575 (Print) 1469-8331 (Online) Journal homepage: www.tandfonline.com/journals/chrs20

'I don't think there's many British African Caribbean men that talk positively about mental health services': Risk, trust, racism and the Mental Health Act

Jeremy Dixon , Caroline Leah , Elaine Craig & Alina Haines-Delmont

To cite this article: Jeremy Dixon , Caroline Leah , Elaine Craig & Alina Haines-Delmont (21 Oct 2025): 'I don't think there's many British African Caribbean men that talk positively about mental health services': Risk, trust, racism and the Mental Health Act, Health, Risk & Society, DOI: 10.1080/13698575.2025.2577454

To link to this article: https://doi.org/10.1080/13698575.2025.2577454

Published online: 21 Oct 2025.

Health, Risk & Society, 2025
Vol. 00, No. 00, 1–19, https://doi.org/10.1080/13698575.2025.2577454

RESEARCH ARTICLE

‘I don’t think there’s many British African Caribbean men that talk positively about mental health services’: Risk, trust, racism and the Mental Health Act

Jeremy Dixon[a], Caroline Leah[b], Elaine Craig[b] and Alina Haines-Delmont[b]

[a]*Centre for Adult Social Care Research, Cardiff University Cardiff, UK;* [b]*Brooks Building, Manchester Metropolitan University Manchester, UK*

(*Received 14 April 2025; Accepted 14 October 2025*)

Abstract

Detention under mental health law is based on professional assessments of risk but impacts on patients’ trust. Little attention has been paid by sociologists to the operation of risk, trust and racism during mental health detention processes. Our study addresses this gap through thirteen qualitative interviews with professionals, conducted in England in 2023 focusing on the mental health detention of British African Caribbean men: a group disproportionately detained. Data were analysed using thematic analysis and the SILENCES framework. Participant accounts highlighted mistrust between British African Caribbean men and mental health services. This group’s mental health was seen to be affected at a macro level by poverty, drug misuse and racism, as well as cultural mistrust and bias. Negative assumptions of British African Caribbean men were seen to operate at a meso level through institutional practices within risk management processes that discriminated against them, leading to coercive treatments and poorer outcomes. Micro level factors were largely absent from interviews. Participants stressed the need to rebuild trust with British African Caribbean communities, but the strategies they described overlooked the macro and meso factors identified elsewhere within interviews. The article is significant in highlighting cultural drivers of (mis)trust between mental health services and British African Caribbean men at macro and meso levels.

Keywords: Risk; trust; racism; risk management; mental health; African Caribbean men

Introduction

Laws allowing the compulsory detention of people with mental health problems exist across jurisdictions (Zhang et al., 2015). Such powers allow individuals to be detained in a hospital and given psychiatric treatment against their will. The legal

Corresponding author. Jeremy Dixon. Email: DixonJ7@cardiff.ac.uk

criteria for detention differ across countries, but normally apply to persons with a 'mental disorder' who are deemed to pose a danger to themselves or others (Saya et al., 2019). Such decisions are based on professional assessments of risk, but these practices can negatively affect trust between mental health professionals and patients (Brown & Calnan, 2012; Vassilev & Pilgrim, 2007). We begin our article by providing details of ethnic inequalities in mental health detention in England, highlighting concerns relating to the disproportionate rates of detention of Black men, in comparison to White groups. We then focus on the issue of trust and mental health law, setting out our position on racism and its effects on mental health detention, and reviewing previous research. We then present our methodology and findings before providing a discussion and conclusion. The purpose of this article is to focus on the issue of trust and mistrust between British African Caribbean men and mental health services in England from the perspectives of professional groups who play a central role in the Mental Health Act detention process – the legal process which permits the detention and treatment of persons with a mental health problem in England and Wales. Current literature on this topic uses the terms Black men, Black African Caribbean men, and British African Caribbean men interchangeably. We use the term British African Caribbean men as this identifies that many of the men being discussed are of Black ethnicity but are also British. However, we use the terms Black men or Black people when referring to papers which relate to the experiences of Black men or people more broadly, including British African Caribbean men.

Context

The detention of British African Caribbean men under mental health law, is one site at which tensions between risk, trust and racism play out. In England, the context of this study, ethnic inequalities within mental health care are seen as a problem by policymakers, with 11 policies focusing on the issue between 1999–2020 (Hussain et al., 2022). In 2008, the National Director for Mental Health acknowledged public criticisms relating to the disproportionate rates of detention of Black people under the Mental Health Act (1983). He wrote,

> 'At the heart of this is issue is trust – or lack of it. I have met young Caribbean men who view mental health services as a branch of the criminal justice system, just another place they can be held in custody. That is a terrible thing to have to admit and an urgent problem to put right' (Appleby, 2008, p. 402).

The issue received further attention when Theresa May (then Prime Minister) commissioned an Independent Review of the Mental Health Act (1983) (GOV.UK [GOV], 2017). The rationale for the review was a 16 per cent increase in mental health detentions between 2016/17 and 202/21 (Bowman, 2023), with Black men detained over four times more often than White people (NHS Digital [NHS], 2018). The review highlighted, 'crucial gaps in trust between service users and providers … ' (DHSC, 2018, p. 20) and the need to reduce rates of detention overall and for Black people in particular. Following this, the Conservative Government proposed a Draft Mental Health Bill, with the bill receiving support from the incoming Labour Government (GOV.UK, 2024).

Trust and mental health Act assessments

Professional health and social care literature has traditionally focused on interpersonal trust; that is trust as it functions at the micro-level (Clark, 2002; Dinç & Gastmans, 2012; Smith, 2001). However, it is important to consider processes of trust as these function at macro- and meso- levels in order to understand the issue from a sociological perspective. Macro level factors, such as governance mechanisms, health infrastructure or policy encourage or discourage trust in mental health services (Bodolica et al., 2016). Trust also occurs at the meso-level, with relationships between patients and professionals being impacted by the trust each has in health institutions, regulators or commissioners (Calnan & Rowe, 2007; Mikesell & Bontempo, 2023). Interpersonal trust is then dependent on micro-level relations; that is relationships between those encountering services and professionals. Patient judgements rely on evaluations of whether professionals hold compatible agendas in which the truster believes the trustee will care for their interests' (Hall et al., 2001, p. 615). They also rest on evaluations of whether a professional is competent (Calnan & Rowe, 2007). Interactions between systems are reflected in 'facework', which connects patients' experiences of direct-interpersonal and abstract systems, with professionals (Brown & Calnan, 2012; Giddens, 1991). In sum, trust relations draw on 'reason, routine and reflexivity' (an individual's interactions with a person or organisation), but are also dependent on a 'leap of faith' involving the 'suspension of risk and vulnerability' (Mollering, 2006, p. 11).

Whilst trust is an important concept within the sociology of health care, it is particularly complex within Mental Health Act assessments. Public perceptions of dangerousness and mental health have shaped macro-level responses to care and treatment, with mental health laws and policies calling on professionals to assess and minimise such risks (Vassilev & Pilgrim, 2007). Such practices reflect the 'politics of anxiety' pervading public imagination which render both patients and professionals untrustworthy. At a meso level, organisational policies and practices impact on levels of trust. Organisational approaches towards Mental Health Act assessments may identify the degree of positive risk-taking they are willing to sanction (in which risk-taking by patients is encouraged to promote recovery) (Alfandari et al., 2022; Campbell & Davidson, 2009; Robertson & Collinson, 2011). However, the levels of risk-tolerance amongst organisations vary, leading to differences in practice across geographical areas. Micro-level practices are also affected by patient awareness of mental health law and risk assessment policies as previous experiences of coercion may lead to distrust towards services (Nyttingnes et al., 2016).

Experience of Mental Health Act assessments are related to a person's ethnicity and have a direct impact on trust. Racism operates at a macro/structural level through historical injustices, such as slavery or colonialism, which position Black people as different or inferior. Resistance to such oppression was historically defined as a form of mental disorder (Burton & Mumba, 2024), although contemporary mental health researchers view macro-level factors such as economic, political and social inequalities as causes of social stress which may lead to or exacerbate mental health problems (Schouler-Ocak et al., 2021). However, critical psychiatrists have argued that psychiatry continues to be Eurocentric in nature, meaning that cultural differences are diagnosed and treated as mental disorders, contributing to structural racism (Fernando, 2010; Shim, 2021). Furthermore, it has been argued that institutional racism is evident through psychiatric hospital regimes which justify increased levels of medication and restraint for Black men due to discriminatory beliefs around their dangerousness (Keating, 2016). Recent reviews and guidance have acknowledged the overlapping nature of structural, institutional and personal racism (DHSC, 2018; RCPsych, 2023). However, there

remains a need to identify how racism and its relationship with risk and trust are viewed by mental health professionals.

Research has shown that Black and minority ethnic groups are significantly more likely to be detained than White people (Heyes et al., 2025), with one meta-analysis showing that their odds of detention are 2.50 higher (Barnett et al., 2019). People of Black or mixed ethnicity show higher levels of distrust towards mental health services, with one cross-sectional study citing higher perceptions of unfair treatment (Henderson et al, 2015) and another reporting fears by service users that mental health services would replicate experiences of racism in wider society (Keating & Robertson, 2004). Additionally, the police are more likely to be involved during Mental Health Act assessments than with White patients (Gajwani et al., 2016). Black people are also more likely to be physically or chemically restrained during treatment (Smith et al., 2022).

Qualitative research has found that Black people's experiences of treatment under detention are predominantly poor. Participants in one study reported, 'I am not a person – I am a black patient' and said that their treatment in hospital wards mirrored racist experiences in society more generally (Solanki et al., 2023, p. 17). However, professional perspectives on the reasons for levels of disproportionate rates of detention amongst British African Caribbean men have been largely neglected. Prior research with multi-disciplinary mental health staff has found that they attribute high levels of detention amongst British African Caribbean men to problems with care systems, including inter-disciplinary mistrust and poor communication; the involvement of police and insufficient consideration for less restrictive care pathways (Bhui et al., 2025). Research also shows that mental health professionals may reiterate cultural stereotypes of Black men being particularly dangerous (Warner & Gabe, 2004). Whilst previous research is helpful, we did not find any peer-reviewed articles which focus specifically on the areas of risk and trust within Mental Health Act assessments with British African Caribbean men.

Methodology

This study is part of a National Institute for Health and Care Research (NIHR) funded project (NIHR 201715) that sought to inform, develop and co-produce practice and policy recommendations for approaches to improve the experiences of British African Caribbean men detained under the Mental Health Act. The project adopted an experience-based co-design (EBCD) approach, which is a participatory action research method (Bate and Robert, 2006). Two research studies were conducted, the first of which was a systematic review (Heyes et al., 2025). The second study consisted of two work packages. This article reports results emerging from the first work package, which was a reflexive thematic analysis (Braun & Clarke, 2021) of thirteen one-to-one qualitative interviews with professionals involved in the mental health detention process. The second work package explored the experiences of British African Caribbean men and their significant others' experiences of mental health services, epistemic injustice, racism, and trauma through arts-based focus groups.

Rather than aiming for large sample sizes, our methods have been used to include participants who can offer rich, experiential insights, particularly those whose voices are traditionally marginalised or underrepresented (Morley et al., 2024). Findings from both work packages were presented to and refined with British African Caribbean men, family members, community leaders, professionals and advocates at evidence-based co-design events with the purpose of informing policy and practice. This article focuses on the

interviews with professionals due to their salience on the topics of risk and trust. Other parts of the wider research are published elsewhere (Craig et al., 2025).

For a detention under the Mental Health Act (1983) to take place, an application is needed from an Approved Mental Health Professional (AMHP) (who coordinates and participates in the assessment) as well as two doctors, one of whom must be approved as having 'special experience in the diagnosis or treatment of mental disorder' (section 12(2), Mental Health Act (1983). For this reason, we aimed to recruit AMHPs and psychiatrists. AMHPs are required to 'provide an independent decision about whether or not there are alternatives to detention' and to bring 'a social perspective' to the assessment (DH, 2015, para 14.52). Assessing doctors are required to make a direct personal medical examination 'of the patient and their mental state' and to consider 'all available relevant clinical information' (DH, 2015, 14.71). We recruited police professionals as police involvement is common where British African Caribbean men are assessed under the Mental Health Act (1983) (Gajwani et al., 2016), although the appropriateness of police involvement in mental health work is often questioned by police (Morgan & Paterson, 2019) We also sought to recruit psychologists who had supported British African Caribbean men in coming to terms with the psychological impact of detention. Invitations to participate were sent to individuals via the lead psychiatrist, the nursing lead, the police equality, diversity and inclusion lead and the Head of AMHP services within the health trust and police force sampled. All gatekeepers informed us that invitations were sent to all professionals who were eligible to take part via email.

Professionals were recruited from a mental health National Health Service (NHS) trust and a police force in the North of England. Census data from the area indicates that Black people make up 12 per cent of the population in this area. This compares to an average of 4 per cent of people identifying as Black in the general population of England and Wales (GOV.UK, 2022). Recruitment took place between February and October 2023. Potential participants were sent recruitment materials through managers in the mental health trust and police service. Information sheets were provided to participants explaining that the research was independent of their employing organisation, the aims of the study, the funder, that research data would be anonymised and the risks and benefits of taking part. Participants were informed that participation was voluntary and that they could withdraw from the study. No financial renumeration was offered. No participants who consented to take part withdrew. Data protection and impact assessments were completed between the lead university and participant organisations. Specific requests were made by participating organisations that identifiable information was not collected and so we did not ask participants for demographic information.

Ethical approval was granted by the Health Research Authority (IRAS 310503). All participants gave written consent prior to taking part. Interviews were conducted online using a secure university Teams account. Interview recordings were sent to a professional transcription service using an encrypted drive with transcripts being returned in this way.

Our sample consisted of five AMHPs, three psychiatrists, four police professionals and one clinical psychologist. Interviews were conducted between February and October 2023. A semi-structured interview format was used. Participants were asked about their role in the detention process, why they believed British African Caribbean men were detained more than their White counterparts, their own experience of detaining/treating British African Caribbean men, how British African Caribbean men could be better supported during the detention process and what they would wish to change. Interpreting questions and non-verbal cues were used to encourage participants to expand

on their responses (Kvale, 1996). All interview participants were invited to attend a meeting in December 2023 where emerging themes were presented. One AMHP, one police professional, one psychiatrist and a psychologist attended and confirmed that the analysis reflected their perspectives.

Data was analysed using thematic analysis (Braun & Clarke, 2021). We adopted a contextualist approach to the data which posits that individuals make meaning from their experience, are influenced by their social context but retain 'agency' to define their own realities. The research project was influenced by the SILENCES framework, which is a theoretical framework designed to explore sensitive issues within marginalised populations (Serrant-Green, 2011). In line with this framework, a systematic review of the literature was conducted, in conjunction with British African Caribbean men with experiences of involuntary treatment and those close to them who have at times provided care to identify silences on the topic of the detention of British African Caribbean men under mental health law (Heyes et al., 2025). The review identified silences in existing research around contextual identity (a tendency amongst existing studies to view Black people as having similar identities to one another), Black people's culture spirituality or religion as well as themes of power, language and communication. Author 2 focused on these issues within the research interviews. In addition to this, efforts were made within coding to identify silences within the data, specifically those identified from the systematic review. The first and second authors independently looked for and discussed aspects related to Mental Health Act detention that were unspoken or unsaid by our participants.

Author 2 and Author 1 coded five transcripts independently. These were discussed, and a coding frame was agreed, which was circulated to Author 4 for feedback. Data were then re-coded by Author 2 and Author 1 using an agreed coding frame. Each researcher kept notes of emerging themes which were discussed in subsequent meetings, with revisions to the coding frame being added. NVivo 14 (Lumivero, 2023) was used to code interviews. Codes were collated into themes by Author 2 and Author 1 and were reviewed at regular intervals.

Findings

Levels of mental illness amongst British African Caribbean men

Participants were aware that our interests lay in exploring rates of Mental Health Act detention amongst British African Caribbean men. When accounting for the discrepancies between ethnic groups, participants cited higher levels of mental illness amongst British African Caribbean men as a contextual factor. Here, they highlighted three overlapping issues. First, they identified that mental ill health was related to poverty, which they felt British African Caribbean men were more likely to experience than White groups. Second, they highlighted that symptoms of mental illness were likely to be caused or exacerbated by drug and alcohol misuse (particularly cannabis misuse), which were perceived as more common within British African Caribbean communities. Third, they stated that mental ill health arose because of structural and institutional racism. For example:

> I feel that Black families here tend to live in poorer areas, for numerous reasons really. I suppose social difficulties, living in poorer areas, possibly experiencing, well likely experiencing racism more, financial difficulties that go along with that, stress, different treatment in school, discrimination … if you are living in a poorer area, possibly where drugs are more rife, people may end up using drugs to cope with the difficult experiences which could then lead to psychosis. (Participant 2 – AMHP)

Here, experiences of poverty and structural racism were seen to provide the context for drug misuse, which was viewed as heightening the risk of mental illness. Not all participants identified these factors together, but they commonly named one or more to explain higher incidence of mental health problems amongst this group.

Trust and British African Caribbean men

The contextual factors which participants identified as driving higher rates of mental health problems in the British African Caribbean men, were also seen as causing their distrust of mental health services. For example:

> 'I don't think that there's that many Black African Caribbean men who talk positively about mental health services and what they have to offer, if you engage with them. It's the narrative in society, if you're a Black Caribbean man. I don't think it would encourage you to go and seek help from mental health services' (Participant 4, Police Professional).[1]

In the above example, Participant 4 identified a lack of engagement between British African Caribbean men in comparison to their White counterparts. Within this interview, reluctance was seen to stem from a perception that mental health services were 'all White'. The dominance of western mental health models within English mental health services were seen to lead to reluctance amongst British African Caribbeans to access them due to cultural differences within Caribbean communities. One participant stated:

> 'I think it's quite a Eurocentric method of accessing mental health support. You talk to your GP [General Practitioner]. Your GP will say, try this, that or the other and I'll refer you on to here. I think that even that initial access point of talking to a GP is something that perhaps Black and minority ethnic men wouldn't think to do. They might talk about it with their peers, they might talk about it in different ways. I think that initial access point is a stumbling block actually'. (Participant 9, AMHP)

Here, the mental health referral process was identified as problematic on the basis that support structures were unappealing to British African Caribbean men and the connections between primary and secondary care services were unclear. In some cases, the lack of trust in institutions was cited as a broader issue which could extend beyond healthcare institutions. For example, Participant 1 (psychiatrist) identified that trust in mental health services was undermined by a legitimate distrust of pharmaceutical companies, due to most medications being developed and tested on White people. However, the exact nature of distrust between African Caribbean communities and mental health services remained opaque. In other words, participants often did not specify *why* the British African Caribbean community distrusted them or what they might prefer, with participants admitting to a lack of knowledge of models of mental health in these communities.

Distrust of mental health services by British African Caribbean men was seen by participants to be influenced by discrimination they experienced from key agencies including the police, mental health professionals and staff in Accident and Emergency Departments. Whilst participants did not state that British African Caribbean men had directly indicated this as a reason for distrust, such discrimination was viewed as detrimental to trust. One participant explained:

> ' … I think through [British African Caribbean men's] interaction with various state institutions, there is usually a degree of unconscious bias which is mostly strongly directed towards young Black men, in terms of assumptions about what their behaviour is likely to be like'. (Participant 1 – Psychiatrist)

The term 'unconscious bias' within this example, was used to highlight an example of individual racism. In line with this participant, others in the sample indicated that discriminatory beliefs about British African Caribbean men held by mental health professionals and the police, specifically the misassumptions that they, 'can be a bigger risk to other people' (Participant 10, Psychiatrist) or that their behaviour was, 'more aggressive and dangerous' (Participant 8, psychologist). Participant 2 (AMHP) also spoke of the 'public and unprofessional perception[s] of risk' related to the term, 'big Black man' influencing the way in which British African Caribbean men were treated. These views were seen by participants to influence decisions about the use of the Mental Health Act. For example:

> ' … and you can see it in some of the language that's used, that talk about aggression, or almost already warning professionals about, "just be on your guard with this one", talking about risk … I definitely see that warning language in referrals when we're talking about Black men. More so than I do in referrals when we're talking about White men. I don't think it's something people are conscious of; I think it just happens. Which is awful, but there's no malice to it'. (Participant 9 – AMHP)

In this example, the participant pointed to unconscious beliefs by mental health staff that British African Caribbean men with mental health problems are particularly dangerous. Whilst the participant made a distinction between conscious and unconscious beliefs about risk, these beliefs were viewed as discriminatory and caused British African Caribbean men to be disproportionately assessed under the Mental Health Act. This then made them subject to the risk assessment procedures operated by health and social care professionals and the police.

Risk procedures and management processes and British African Caribbean men

Organisational approaches to risk were seen as central to the way in which British African Caribbean men were treated by the mental health system. In other words, because these men were more likely to be stereotyped as a danger to others, they were more likely to be affected by procedures for managing risk. Whilst such discrimination was often portrayed by participants as occurring at an individual level, there were also instances where the term 'institutionalised racism' was used, although this was solely applied to the police. Police risk procedures were highlighted by other professionals and were characterised as inflexible. For example:

> ' … he [patient] assaulted a police officer, but when we got him to A and E [Accident and Emergency] they didn't need to keep him in the 'cuffs. They could have uncuffed him. The police were like, "we're not going to leave you, he's a risk". But then, I'm a professional. I can risk assess a situation … I think the police can be quite heavy handed sometimes. That's my experience anyway'. (Participant 3, AMHP)

In this example, the police's use of handcuffs was seen as problematic with the participant highlighting disagreements as to who should have the authority to assess risk or

safety. Police participants were acutely aware of criticisms of the police as 'institutionally racist', from public inquiries (Casey, 2023; MacPherson, 1999). These participants differed in the extent to which they accepted such criticisms, but all police participants presented their role as ensuring public safety. Use of force was then justified on this basis. For example:

> 'So, I don't think we go, 'It's a Black person, let's hand "cuff them", I just don't think that happens. But I think maybe the communication because of [a] potential cultural issues or other, perhaps is not as good as it would be with somebody from a different ethnicity, or if the officer was Black, speaking to a Black person, that might be better but we're never going to get that. If there's an emergency, we're going, whoever we are. We have to and we're never going to change that. These are emergencies'. (Participant 11, Police)

Here, reference to 'potential cultural issues' acted as an acknowledgement that police procedures failed to acknowledge legitimate distress from Black people. However, this point was then minimised, with restraint being justified on the basis that they were responding to 'emergency situations'. This view was highlighted by other police participants who also highlighted that such roles were often assigned to junior officers who would be subject to sanction, should things go wrong, although this point was not further developed interviews.

Police participants expressed frustration with health-related practices around risk, although did so for different reasons. For example, one participant stated,

> 'In line with [police] policy, he was taken by ambulance and rushed directly to a hospital . . . His behaviour was manic. He was aggressive, excessively strong, being violent, refusing to dress, unable to engage. A doctor came and saw him, who was himself of ethnic background [and said], "We're not treating him here. Take him to custody, he can be dealt with there". He was brought back to custody, and they were that concerned the paramedic sat in the back of the police van . . . [I] couldn't get my head around it' Participant 13. (Police Officer)

The above quotation highlights discrepancies amongst agencies about how a risk of violence, due to a mental health problem, should be dealt with. The police participant's description of the person's behaviour being 'manic', 'excessively strong' and 'unable to engage' can be viewed as reflecting stereotypes about British African Caribbean men with mental health problems as being particularly dangerous. However, in this instance the terms were also used to highlight the primacy of the mental health label with attention being drawn to the way that the person was taken to hospital 'in line with [police] policy'. The phrase, 'I couldn't get my head around it', was then used to identify how risk procedures by health systems were viewed as unfathomable and erratic, being used to deny hospital admission. The quotation also reflected a wider view amongst police participants that mental health risks should be managed by mental health services, and that the police's involvement in such cases should be drastically reduced.

Criticisms of risk assessment processes were not limited to the police. Participants identified problems with racist assumptions about British African Caribbean men from health or social care teams. The term 'institutional racism' was not used, although participants recounted instances of group think, where teams held discriminatory assumptions about British African Caribbean men. One participant recounted a situation in which the police were called to see a patient but felt that they were not an acute risk and so left them at home. A referral was then made to the Crisis Team whose role is to offer intensive support and thus reduce the likelihood that patients are

detained in hospital. The Crisis Team refused to see the person and referred him to the AMHP service for an assessment under the Mental Health Act. The AMHP involved in the case said:

> ' . . . the challenging bit was trying to have those conversations with the [Crisis Team] professionals about how they were describing this person. And they were really defensive to when I was trying to have that conversation with them. They were basically putting that back on me, and saying I was, what did they say? Something like, I wasn't taking the risk seriously or something, or that I was putting staff at risk'. (Participant 6, AMHP)

Here, tension between agencies occurred due to the way that 'risk' was being used to describe a British African Caribbean man, with the AMHP arguing that it reflected discriminatory beliefs about the dangerousness they were seen to pose. In other words, the AMHP was critical of the term 'risk' being used as a neutral social-moral category to refuse care to the patient in question on the grounds that they might pose a risk of violence to staff. In making this observation, the participant was pointing to racist stereotypes which were reflected within responses by the crisis team. The example was also used to highlight that the category of 'risks to staff' were used as a means to deny community treatment, thereby making an assessment and detention under the Mental Health Act more likely.

Talking to British African Caribbean men

A noticeable omission in participant accounts was of conversations with British African Caribbean men. Where this did occur, participants highlighted difficulties in trust due to suspicions from them. One police participant said:

> 'You've probably heard that the police spend a lot of time [with] people waiting for them to actually have the assessment . . . even though they're poorly, you would usually get to know quite a bit about them. I would suggest that the main difference is that even though they [British African Caribbean men] might have a laugh and a joke with you, overall they wouldn't share a lot of personal information about themselves, which I found a little bit different'. (Participant 4, Police)

In a similar vein, Participant 2 noted that British African Caribbean men could be reluctant to talk during Mental Health Act assessments. In their accounts, they highlighted the importance of giving the person space and persisting with efforts to talk to them. They said,

> 'So, I think it is definitely important, well in all assessments, but particularly with Afro Caribbean men, because the last thing you want is for them to feel that they haven't been assessed fairly or interviewed fairly at a later date. If they suddenly started thinking, 'they left after five minutes – I was agitated but I was just worried about it [the Mental Health Act assessment]. It doesn't bode well'. (Participant 2, AMHP)

However, it was notable that accounts of conversations between British African Caribbean men and mental health professionals were largely omitted by participants. Our participants interpreted this as being due to suspicion and a lack of dialogue between professional groups and the British African Caribbean community. However, it may also reflect a lack of effort by professionals to engage with British African Caribbean men within Mental Health Act assessment interviews. This is significant, given that most

Mental Health Act assessment consists of an interview between the assessed person, two doctors and the AMHP co-ordinating it and inform decisions as to whether a person should be detained.

Re-establishing trust

The lack of trust between British African Caribbean men and mental health services was seen as a serious problem by participants. A notable feature of interviews was that participants frequently spoke about ways in which trust might be formed. Two solutions were given. First, more diverse recruitment policies were seen as necessary. Participants observed that most AMHPs, psychiatrists and police professionals were White. For example,

> 'A lot of the doctors that do the assessment – I feel like I'm being stereotypical, but they're either White males, or they're Asian males or they're White females. It's very rare that you would get anybody from the Black African Caribbean community who's actually involved in the assessment. There's the odd AMHP, but that's it really'. (Participant 4, Police Professional)

Participants hypothesised that British African Caribbean men would conclude that a service which did include members from their community would not understand their views around mental health. Consequently, some felt that greater workforce diversity was necessary to establish trust. For example,

> 'I think for a generalised answer, it would be helpful to have a more diverse workforce within mental health services and particularly during the Mental Health Act assessment process, whether that's doctors or AMHPs. When I'm arranging an assessment, I always try and think about whether it would be possible to arrange a doctor who was Black, or culturally similar . . . '. (Participant 2, AMHP)

Similarly, another participant commented that 'if somebody looks like you, you have more shared understanding, you understand the culture and difficulties a little bit more' (Participant 8, Psychologist). Whilst more inclusive recruitment strategies were viewed as positive by many, several participants qualified this position. Participant 2 (AMHP), gave an example of a Black AMHP, being accused of being 'a fake Black man' by an African Caribbean patient. Other participants also highlighted that workforce diversity might not overcome distrust. One participant said:

> ' . . . actually, we've got a lot of Black staff . . . and that doesn't seem to be particularly helpful in our minds . . . for example, the Nigerian man, who was the last man we had in [the hospital ward], was very contemptuous of some of the staff from other African countries . . . So from his point of view, he didn't see it all as, well – we're Black together, but rather, I'm a Nigerian man'. (Participant 5, Psychiatrist)

Here, the participant highlighted potential discrimination between Black groups. This participant also identified that a more diverse workforce would not instil confidence in British African Caribbean men, if that workforce were predominantly working in lower grade jobs.

A second strategy suggested by participants, was the need for more outreach strategies to the British African Caribbean community. Individuals highlighted a need to create a dialogue between services and this community. For example:

> 'I think a huge part of that is, people like me or other professionals going into communities and actually saying, "This is what psychosis is, and this is an experience of what low mood can look like" . . . .And there's a lot of two-way communication which needs to take place, which, at the moment, is not, at least from an NHS [National Health Service] perspective'. (Participant 8, Psychologist)

In this example, the main weight of responsibility for establishing trust was placed on the NHS, although one participant highlighted the responsibility as reciprocal with British African Caribbean communities being responsible for addressing problems within 'their own culture, their own people and communities' (Participant 13, Police Professional).

Whilst engagement with the British African Caribbean communities was seen as desirable, there was some variance amongst participants as to what the focus should be. Some participants advocated a community outreach approach to identify prejudice amongst services. Participants also supported mental health education, although there were differences as to how far the views of British African Caribbean communities should be accepted. On the one hand, different framings of mental health were viewed as equal to western models. For example, one AMHP thought that it was important to understand people's beliefs about mental health, stating that 'it doesn't fit into the Western medical knowledge. Nor should it' (Participant 6, AMHP). In other cases, professionals identified that their task was primarily around educating people about 'scientific' representations of mental health. One psychiatrist said,

> 'You don't come up with an idea that your brain might be blancmange, if you know that its full of neurons. So cultural background influences not only your presentation of psychosis but also your perception of its course and treatment, for sure'. (Participant 10, Psychiatrist)

Here, Western psychiatric epistemology was reified, with the participant identifying the primary purpose of education as being to inform those in the British African Caribbean community of the biological basis of mental disorder. In this case, outreach was seen as a didactic educational process, rather than reflecting an equal partnership between members of the British African Caribbean community and professionals.

Discussion and conclusion

Quantitative research evidence has identified that Black men are detained more frequently than their White counterparts, with multiple papers citing mistrust and alienation from services as being primary factors (Barnett et al., 2019). Whilst several sociological articles have focussed on the nature of trust within mental health services (Brown & Calnan, 2012; 2016; Vassilev & Pilgrim, 2007) none have focussed directly on the issue of detention under the Mental Health Act. Participants in our study cited high levels of distrust amongst British African Caribbean communities, which align with the accounts of African Caribbean people within former research studies (Keating & Robertson, 2004; Knight et al., 2024).

In seeking to understand how notions of risk, racism and trust intersect in the accounts of professionals, we need to consider how they accounted for trust and distrust at macro, meso and micro levels. Nazroo et al. (2020) have argued that there is a tendency amongst mental health professionals to highlight social (macro) factors, such as poverty and racism, when considering ethnic inequalities in mental health care. They view this as a process of 'othering' through which professionals avoid taking responsibility for the pervasive effects of racism in communities or a need to improve services provided in these communities. Our participants identified distrust as occurring between British African Caribbean men and mental health services within the context of such factors, which were all seen to heighten the risk of Mental Health Act assessments taking place. In taking this view, participants were highlighting common perspectives within the mental health literature, that social inequality and racism exacerbate mental distress (Schouler-Ocak et al., 2021). However, this position did not appear to reflect a process of 'othering' by all. Some AMHPs and the psychologist were critical of such perspectives, aligning with the views of critical psychiatry (Fernando, 2010), that sees Eurocentric assumptions within diagnostic systems as a form of structural oppression, and which calls for more recognition of culturally appropriate therapies. In addition to this, a psychiatrist in the study highlighted Eurocentric practices within the pharmacology industry as a legitimate cause for distrust. Both observations, identified health infrastructures as creating distrust and thus indicated a more progressive position by some mental health practitioners.

Brown et al have argued that trust and distrust within mental health systems are enacted at a meso-level through, 'instrumental-strategic tendencies across organisations, [which] assist in explaining the emergence of broader organisational patterns of (dis)trust and (poor) quality care' (Brown & Calnan, 2016, p. 300). Participants in our study commonly highlighted individual prejudices which were held by professionals about the danger that British African Caribbean men posed to others (reflecting Warner & Gabe, 2004). These beliefs then caused these men to be subject to meso-level factors, namely local policies regarding risk and consequently had an impact on the level of trust between British African Caribbean men and mental health services. Several participants in our study identified and made direct reference to national inquiries highlighting 'institutional racism' within the police. In making this claim, they were highlighting the notion that racism can be perpetuated through attitudes and behaviours which 'amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping' (MacPherson, 1999, para 6.34). These arguments were deployed by some AMHPs, psychiatrists and the psychologist. They argued that policies and procedures around use of physical restraint and handcuffs by police were examples of such prejudice which harmed British African Caribbean men and perpetuated distrust of the mental health system by association.

Police participants sought to discount criticisms of institutionalised racism in two ways. First, they emphasised that the risk posed by British African Caribbean men was a health risk. This argument aligns with criticisms made by the police elsewhere, that mental health professionals avoid responsibility for managing mental health risks, leaving the police to pick up the pieces (Lane, 2019; Morgan & Paterson, 2019). Second, police participants stated that in the absence of mental health care being available, the police had no option but to use force. In making this assertion, police assessments about risk to the public were seen to have primacy above other professionals' assessments of risk to patients.

Our findings reflect those in other research in which police participants voiced views that coercion was necessary when working with people with mental health problems, viewing alternatives as naïve or idealistic (Lane, 2019). Whilst the mental health professionals and the police disagreed as to whether force was justified, this example can be seen as an example of a chain of distrust, in that micro mechanisms within intra-organisational relationships (in this case, health services, the local authority and the police) were viewed as impacting on the establishment of trust with patients (Brown & Calnan, 2016), with all parties agreeing that the processes led to coercive practices. Ultimately, British African Caribbean men were seen as disproportionately being subject to police risk management procedures, which sanctioned coercion to protect the public and police officers themselves from risks which they were assumed to pose to others.

Meso-level chains of distrust were not limited to relationships between mental health professionals and the police but also existed between different parts of the health and social care system. Participants in our study described British African Caribbean men being refused access to different mental health services because of their high level of 'risk'. Within such accounts, risk was used as a neutral social-moral category, through which a power-related process of 'othering' took place (Douglas, 1992). Participants in our study indicated that these judgements were not reflected through formal risk assessment tools but through discussions amongst teams as to which patients were risky. In this respect, our findings have some similarities with previous research, in which some professionals identified Black men with mental health problems as particularly dangerous (Warner & Gabe, 2004), except here these judgements were formed and held collectively within specific mental health teams. Participants did not use the term 'institutionalised racism' to describe such cases. This may have been because the concept of institutional racism has not been invoked in mental health inquiries to describe Black men's mistreatment, despite distinct similarities with practices used by the police (Keating, 2016). However, the examples cited reflected institutional policies which disadvantaged British African Caribbean men, which AMHP and social care professionals had been critical of when referring to the police. 'Risks' to staff were then used to cordon off access to less coercive treatments, such as intensive community care, making detention within subsequent Mental Health Act assessments more likely.

Our project was informed by the SILENCES framework, which encourages researchers to reflect on what is unsaid about marginalised communities, which may impact on their life-chances (Serrant-Green, 2011). A significant silence within professional' accounts was around language and communication within micro-level interactions between professionals and British African Caribbean men within Mental Health Act assessments themselves. Given that decisions about detention occur following an interview between a patient, an AMHP and two doctors, one might assume that such conversations might have been central to professional' accounts. Previous research has found that trust between patients and mental health services can still be formed despite previous negative experiences (Brown & Calnan, 2012; Moth, 2023). These trusting relationships are formed in cases where patients experience practitioners as being empathic, showing respect and being listened to. It is not possible for us to say from our data whether these factors apply to Mental Health Act assessments with British African Caribbean men. However, future research in this area might usefully focus on mechanisms of trust and trust-building at a micro-level.

A dominant concern amongst our participants was how trust might be established between mental health services and British African Caribbean men. This followed from concerns around high levels of ill health amongst the British African Caribbean community (caused by macro factors including racism) and inter-agency practices. Younis (2021) has argued that debates about racism in mental health care have tended to reflect neoliberal agendas (emphasising patient choice) and have posited diversity policies and training as the solution to racism. Participants in our study emphasised the need for workforce diversity but held different views about it. Workforce diversity was seen by some as one means through which racial mental health disparities might be reduced, with the assumption that Black staff would recognise and be able to bridge cultural differences. These views reflected the aims of racial profiling policies within the police, which have aimed to recruit higher levels of people from ethnic minorities to services to reduce racism and discrimination, although the outcomes of such programmes have been mixed (*see*, Hong, 2017). Other participants highlighted criticisms of such measures, through identifying that Black staff often lacked the power to challenge meso-level structures (Kyere & Fukui, 2023). Others felt that trust might be re-established through community engagement, a concept that does not feature heavily in the mental healthcare literature. However, in several instances, what was described was akin to a psychoeducation in which patients are educated about the causes and effects of mental health, with western models being reified. In giving such accounts participants failed to see Western psychiatric models as a macro-factor which might affect British African Caribbean men's experiences of racism and positioned British African Caribbean communities and men as responsible for accepting such views, reflecting individualised choice agendas within mental healthcare (Younis, 2021).

Our research project has several limitations. Our sample reflected the experiences of mental health professionals in one large urban English locality, and these experiences may be different elsewhere. Despite recurrent attempts to recruit participants, our sample size was small. AMHPs and doctors are key decision-makers within the Mental Health Act process, but we were only able to recruit five AMHPs and three doctors. A larger sample size in both groups may have reflected a wider range of tensions between medical and social models of distress which are often inherent within Mental Health Act decision making and have been demonstrated in other Mental Health Act research (Peay, 2003). Furthermore, we were not able to recruit police participants who were police constables, or other police participants holding more senior roles. The police Equality Diversity and Inclusion lead informed us that the low number of police participants coming forward may have been due to a mistrust amongst police about how their responses could be interpreted, due to an inquiry into racism within the Metropolitan Police Force around this period (Casey, 2023). Other participant groups did not inform us for their reasons for not taking part. Response rates may have been limited through recruitment within one health Trust and may also have been affected by service and work pressures, with interviews taking place shortly after the Covid pandemic.

Evidence based co-design uses findings from separate work packages to inform findings from future work packages. This article focuses on one work package only. Taken in isolation, the findings from this work package can be viewed as exploratory due to the reported sample size (although these themes were further developed through qualitative research with British African Caribbean men, their significant others, and British African Caribbean communities in the sampled area, which are reported elsewhere). Use of other qualitative methods, such as ethnographic research would have provided greater

opportunities to observe how risk is understood in health, social care and police settings and to observe where instances of structural or institutional racism were evident. Demographic details of our participants such as age, gender, ethnicity and level of experience were not recorded and this data may have shed more light on participants' positionality. Despite these limitations our project reveals some important insights into professional perspectives on risk and trust during Mental Health Act assessments with British African Caribbean men.

Conclusion

Previous sociological research has focussed on the operation of trust within mental health services (Brown & Calnan, 2012; Vassilev & Pilgrim, 2007). These studies have noted a tension within mental health policy, with services highlighting the need for patient led care, whilst also emphasising the need for risk management. However, sociological analyses of how trust, racism and risk operate within mental health detention processes have been lacking. Our study is original in exploring this issue through interviews with professionals involved in detentions under the Mental Health Act (1983) which involves the disproportionate detention of British African Caribbean men. The accounts of professionals in our study identified high levels of distrust between British African Caribbean men and mental health services, with these participants highlighting the impact of macro factors, namely poverty, drug misuse and racism within British Caribbean communities. Meso level explanations were also articulated, namely risk management processes through which institutionally prejudiced responses were perpetuated leading to high levels of police involvement and detention under the Mental Health Act. Micro level explanations were largely absent within participant interviews. Whilst participants identified the need for mental health services to rebuild trust with British Caribbean men, the strategies they identified largely ignored the macro and meso explanations provided elsewhere within interviews.

Funding

The work was supported by the National Institute for Health and Care Research [NIHR 201715].

Note

1. Our title draws on this quote, although we have adapted it, changing the participant's reference to 'Black African Caribbean men', to 'British African Caribbean men'. We have done this so that the terminology used in the title and article are consistent.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Author contributions

CRediT: **Jeremy Dixon:** Formal analysis, Funding acquisition, Methodology, Writing – original draft; **Caroline Leah:** Conceptualization, Formal analysis, Funding acquisition, Methodology, Writing – review & editing; **Elaine Craig:** Writing – review & editing; **Alina Haines-Delmont:** Conceptualization, Data curation, Funding acquisition, Writing – review & editing.

References

Alfandari, R., Taylor, B. J., Baginsky, M., Campbell, J., Helm, D., Killick, C., Sicora, A., Mullineux, J., Shears, J., Sicora, A., & Whittaker, A. (2022). Making sense of risk: Social work at the boundary between care and control. *Health, Risk & Society*, *25*(1–2), 1–18. https://doi.org/10.1080/13698575.2022.2147904

Appleby, L. (2008). Services for ethnic minorities: A question of trust. *Psychiatric Bulletin*, *32*(11), 401–402. https://doi.org/10.1192/pb.bp.107.018895

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Smith, S., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the mental health Act: A systematic review and meta-analysis of international data. *Lancet Psychiatry*, *6*(4), 305–317. https://doi.org/10.1016/S2215-0366(19)30027-6

Bate, P., & Robert, G. (2006). Experience-based design: From redesigning the system around the patient to co-designing services with the patient. *BMJ Quality & Safety*, *15*(5), 307–310. https://doi.org/10.1136/qshc.2005.016527

Bhui, K., Mooney, R., Joseph, D., McCabe, R., Newbigging, K., McCrone, P., Husain, N., Keating, F., & Husain, N. (2025). Professional experiences on use of the mental health act in ethnically diverse populations: A photovoice study. *BMJ Ment Health*, *28*(1), e301406. https://doi.org/10.1136/bmjment-2024-301406

Bodolica, V., Spraggon, M., & Tofan, G. (2016). A structuration framework for bridging the macro-micro divide in health-care governance. *Health Expectations*, *19*(4), 790–804. https://doi.org/10.1111/hex.12375

Bowman, D. (2023). Theresa May and mental health policy: A legacy unfinished? In A. S. Roe-Crines & D. Jeffery (Eds.), *Statecraft. Policies and politics under Prime Minister Theresa May* (1 ed. pp. 137–160). Palgrave Macmillan.

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical Guide*. Sage.

Brown, P., & Calnan, M. (2012). *Trusting on the edge: Managing uncertainty and vulnerability in the midst of serious mental health problems*. Policy Press.

Brown, P. R., & Calnan, M. W. (2016). Chains of (dis)trust: Exploring the underpinnings of knowledge-sharing and quality care across mental health services. *Sociology of Health and Illness*, *38*(2), 286–305. https://doi.org/10.1111/1467-9566.12369

Burton, W. M., & Mumba, M. N. (2024). Race as a structural determinant of mental health. *Journal of Psychosocial Nursing and Mental Health Services*, *62*(2), 3–5. https://doi.org/10.3928/02793695-20240109-01

Calnan, M., & Rowe, R. (2007). Trust and health care. *Sociology Compass*, *1*(1), 283–308. https://doi.org/10.1111/j.1751-9020.2007.00007.x

Campbell, J., & 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), 249–263. https://doi.org/10.1080/17496530903209469

Casey, L. (2023). *Baroness Casey Review. Final report. Into the of and of the metropolitan police force*. Retrieved from the Metropolitan Police. https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf

Clark, C. C. (2002). Trust in medicine. *The Journal of Medicine and Philosophy*, *27*(1), 11–29. https://doi.org/10.1076/jmep.27.1.11.2975

Craig, E. M., Leah, C., Dixon, J., Bergqvist, A., Brorick, I., Best, D., Heyes, K., Duxbury, J., & Haines-Delmont, A. (2025). From mental health detention to health systems reform: Co-producing policy and practice recommendations with black men, their communities and health and social care professionals. *PLOS Mental Health*, In Press.

Department of Health, Mental Health Act 1983: Code of Practice. (2015). *Department of Health*.

DHSC. (2018). *Modernising the mental health act. Increasing choice, reducing compulsion. Final report of the Independent review of the Mental Health Act 1983*. Retrieved from Gov.UK.

Dinç, L., & Gastmans, C. (2012). Trust and trustworthiness in nursing: An argument-based literature review. *Nursing*, *19*(3), 223–237. https://doi.org/10.1111/j.1440-1800.2011.00582.x

Douglas, M. (1992). *Risk and blame: Essays in cultural theory*. Routledge.

Fernando, S. (2010). *Mental health, race and culture* (3rd ed.). Bloomsbury Publishing.

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 & Psychiatric Epidemiology*, *51*, 703–711. https://doi.org/10.1007/s00127-016-1181-z

Giddens, A. (1991). *Modernity and self-identity: Self and Society in the late Modern age*. Polity.

GOV.UK. (2017). Prime minister announces review to tackle detention of those with mental ill health. https://www.gov.uk/government/news/prime-minister-announces-review-to-tackle-detention-of-those-with-mental-ill-health

GOV.UK. (2022). Population of England and Wales. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest/

GOV.UK. (2024). The King's speech 2024. https://www.gov.uk/government/speeches/the-kings-speech-2024

Hall, M. A., Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *The Milbank Quarterly*, *79*(4), 613–639. https://doi.org/10.1111/1468-0009.00223

Henderson, R. C., Williams, P., Gabbidon, J., Farrelly, S., Schauman, O., Hatch, S., Thornicroft, G., Bhugra, D., Clement, S., & Group, M. S. (2015). Mistrust of mental health services: Ethnicity, hospital admission and unfair treatment. *Epidemiology and Psychiatric Sciences*, *24*(3), 258–265. https://doi.org/10.1017/S2045796014000158

Heyes, K., Brodrick, I., Best, D., Thompson, K., Leah, C., Miller, E., Haines-Delmont, A., Serrant, L., Dixon, J., Bergqvist, A., Lantta, T., Sewell, H., Tourish, C., Whyte, R., Duxbury, J., & Haines-Delmont, A. (2025). A co-produced review of the experiences of black male detention under mental health legislation: Challenging discrimination in psychiatry using the silences framework. *PLOS Mental Health*, *2*(4), e0000041. https://doi.org/10.1371/journal.pmen.0000041

Hong, S. (2017). Black in blue: Racial profiling and representative bureaucracy in policing revisited. *Journal of Public Administration Research & Theory*, *27*(4), 547–561. https://doi.org/10.1093/jopart/mux012

Hussain, B., Hui, A., Timmons, S., & Nkhoma, K. (2022). Ethnic mental health inequalities and mental health policies in England 1999-2020. *Journal of Public Mental Health*, *21*(2), 162–173. https://doi.org/10.1108/JPMH-06-2021-0080

Keating, F. (2016). Racialized communities, producing madness and dangerousness. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, *5*(3), 173–185 doi:https://doi.org/10.48336/IJHCOW5488.

Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health & Social Care in the Community*, *12*(5), 439–447. https://doi.org/10.1111/j.1365-2524.2004.00506.x

Knight, S., Yang, X. Q., & Jarvis, G. E. (2024). "Dem sey mi mad": A scoping review of the attitudes and beliefs of English-speaking Afro-caribbeans about psychosis. *Frontiers In Psychiatry*, *15*, 1385525. https://doi.org/10.3389/fpsyt.2024.1385525

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Sage.

Kyere, E., & Fukui, S. (2023). Structural racism, workforce diversity, and mental health disparities: A critical review. *The Journal of Racial and Ethnic Health Disparities*, *10*(4), 1985–1996. https://doi.org/10.1007/s40615-022-01380-w

Lane, R. (2019). "I'm a police officer not a social worker or mental health nurse": Online discourses of exclusion and resistance regarding mental health-related police work. *Journal of Community & Applied Social Psychology*, *29*(5), 429–442. https://doi.org/10.1002/casp.2410

Lumivero. (2023). Nvivo (version 14). www.lumivero.com.www.lumivero.com

MacPherson, W. (1999). *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William Mcpherson of Cluny advised by Tom Cook, the right Reverend Dr John Sentamu, Dr Richard Stone*. Retrieved from Gov.UK. https://assets.publishing.service.gov.uk/media/5a7c2af540f0b645ba3c7202/4262.pdf

Mental Health Act. (1983).

Mikesell, L., & Bontempo, A. C. (2023). Healthcare providers' impact on the care experiences of patients with endometriosis: The value of trust. *Health Communication*, *38*(10), 1981–1993. https://doi.org/10.1080/10410236.2022.2048468

Mollering, G. (2006). *Trust: Reason, routine, reflexivity*. Elsevier.

Morgan, M., & Paterson, C. (2019). 'It's mental health, not mental police': A human rights approach to mental health triage and Section 136 of the mental health Act 1983. *Policing A Journal of Policy and Practice*, *13*(2), 123–133. https://doi.org/10.1093/police/pax047

Morley, C., Jose, K., Hall, S. E., Shaw, K., McGowan, D., Wyss, M., & Winzenberg, T. (2024). Evidence-informed, experience-based co-design: A novel framework integrating research evidence and lived experience in priority-setting and co-design of health services. *BMJ Open*, *14*(8), e084620. https://doi.org/10.1136/bmjopen-2024-084620

Moth, R. (2023). Understanding mental distress: Knowledge, practice and neoliberal reform in community mental health services. In *Practice and Neoliberal Reform in community mental health services*. Policy Press.

Nazroo, J. Y., Bhui, K. S., & Rhodes, J. (2020). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health and Illness*, *42*(2), 262–276. https://doi.org/10.1111/1467-9566.13001

NHS Digital. (2018). Mental health Act statistics, annual figures 2017-18. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'-patients' expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry*, *49*(Part A), 147–153. https://doi.org/10.1016/j.ijlp.2016.08.009

Peay, J. (2003). *Decisions and dilemmas: Working with mental health law.* Hart Publishing.

RCPsych. (2023). *Act against racism: Tackling racism in the workplace*. Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/act-against-racism/tackling-racism-in-the-workplace.pdf?sfvrsn=d926586f_2

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society*, *13*(2), 147–164. https://doi.org/10.1080/13698575.2011.556185

Saya, A., Brugnoli, C., Piazzi, G., Liberato, D., DiCiaccia, G., Niolu, C., & Siracusano, A. (2019). Criteria, procedures, and future prospects of involuntary treatment in psychiatry around the world: A narrative review. *Frontiers In Psychiatry*, *10*, 271. https://doi.org/10.3389/fpsyt.2019.00271

Schouler-Ocak, M., Bhugra, D., Kastrup, M., Dom, G., Heinz, A., Küey, L., & Gorwood, P. (2021). Racism and mental health and the role of mental health professionals. *European Psychiatry*, *64*(1), e42. https://doi.org/10.1192/j.eurpsy.2021.2216

Serrant-Green, L. (2011). The sound of 'silence': A framework for researching sensitive issues or marginalised perspectives in health. *Journal of Research in Nursing*, *16*(4), 347–360. https://doi.org/10.1177/1744987110387741

Shim, R. S. (2021). Dismantling structural racism in psychiatry: A path to mental health equity. *The American Journal of Psychiatry*, *178*(7), 592–598. https://doi.org/10.1176/appi.ajp.2021.21060558

Smith, C. (2001). Trust and confidence: Possibilities for social work in'high modernity'. *British Journal of Social Work*, *31*(2), 287–305. https://doi.org/10.1093/bjsw/31.2.287

Smith, C. M., Turner, N. A., Thielman, N. M., Tweedy, D. S., Egger, J., & Gagliardi, J. P. (2022). Association of black race with physical and chemical restraint use among patients undergoing emergency psychiatric evaluation. *Psychiatric Services*, *73*(7), 730–736. https://doi.org/10.1176/appi.ps.202100474

Solanki, J., Wood, L., & McPherson, S. (2023). Experiences of adults from a black ethnic background detained as inpatients under the mental health Act (1983). *Psychiatric Rehabilitation Journal*, *46*(1), 14–20. https://doi.org/10.1037/prj0000537

Vassilev, I., & Pilgrim, D. (2007). Risk, trust and the myth of mental health services. *Journal of Mental Health*, *16*(3), 347–357. https://doi.org/10.1080/09638230701299178

Warner, J., & Gabe, J. (2004). Risk and liminality in mental health social work. *Health, Risk & Society*, *6*(4), 387–399. https://doi.org/10.1080/13698570412331323261

Younis, T. (2021). The muddle of institutional racism in mental health. *Sociology of Health and Illness*, *43*(8), 1831–1839. https://doi.org/10.1111/1467-9566.13286

Zhang, S., Mellsop, G., Brink, J., & Wang, X. (2015). Involuntary admission and treatment of patients with mental disorder. *Neuroscience Bulletin*, *31*(1), 99–112. https://doi.org/10.1007/s12264-014-1493-5