Black men's experiences of the secure care pathway.

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This report provides findings from a series of group discussions with black men in secure mental health care services. The project sought to understand their common experiences and ideas to identify actions, activities and services which may prevent unnecessary admissions and support recovery in the community.

Throughout this report the men are referred to as *"Black"* this imprecise term encompasses a wide group of people from different backgrounds, cultures and faiths including British, African and Caribbean. Although the term includes diverse and complex groups it is used as a catch-all as used by participants who self-selected to join discussions about secure services for 'black men'.

Method

Nine two hour group discussions were arranged with men from secure hospitals across the country. The conversations were led by a facilitator, supported by a team including Experts by experience and two note takers. The discussion followed a topic guide which explored different stages of the pathway from community through to secure care. Participants were asked to use their insight and experiences to describe how a hypothetical young man might progress through various journeys through the services. The conversations allowed participants to draw on their own experiences of secure services, following through to release, recovery and support in the community. The group discussion concluded with constructive suggestions for improving recovery and release into the community.

Analysis

After each discussion handwritten notes were typed by both researchers independently who then read through and coded these to identify the main themes. These are presented below as three different sections, to highlight common experiences and identify issues that could prevent unnecessary admissions and improve community services that can support men in their recovery. There is some overlap and repetition in the three sections as they present different cross sections through the data.

Report structure

The main report is presented in two broad sections. The first which covers the journey through secure care is divided into three sub sections, starting with the individuals as they experience the first symptoms, through to the experience in secure services and ending with recovery and discharge into the community. Each sub section is summarised by briefly outlining the impact that different agencies and individuals may have on the pathway. The second section describes common themes which are repeated across the journey and need to be considered separately. These cross cutting themes include issues such as stereotyping and the perception and awareness of unfairness across the pathway.

Patient journey into care

Patient journey into care

1. Community

1.1 Social experiences before symptoms

Participants depicted a range of circumstances typified by disadvantage, discrimination and oppression which they believed had contributed directly to their journey into secure care. They often indicated that their struggle was a consequence of living in a socio-economically disadvantageous position, which included growing up in areas surrounded by violence, drugs and often an absence of meaningful relationships.

The men often described being 'let-down' by services that were supposed to support them. One a young man, for example, described how social services had failed to pass on his details when moving between foster homes in a northern city to one in the south of England. This broke the continuity of support from CAMHS were he had been progressing. He described feeling as if he was part of an experiment as they unsuccessfully attempted to match him with several foster parents of a similar race and/or nationality.

Additionally, some participants who had come from areas of war and conflict shared specific and personal experiences about the psychological effects of witnessing killings and being victims of atrocities during periods of civil war in their country of origin.

1.2 Societal Racism:

The socio-economic hardship that participants reported was further exacerbated by the experience and perception of racism. Participants were very aware of social inequalities and unfairness across the journey. Some pointed to racism which they saw as the bedrock on which society was built. They described being taught they were inferior to others from a young age and had experienced racism from individuals and agencies long before experiencing any mental ill health symptoms.

There was a sense that racism in society was repeated along with structural inequalities in areas such as housing, education and employment. Along with these participants felt the impact of racial stereotypes which expected and suspected them of being criminals. Participants also talked about struggling against internalising these negative social expectations.

1.3 First symptoms

There were several different routes into secure care each of which was linked to the level of awareness about symptoms for the individual and among their support network.

Participants tended to describe the experience of mental illness as confusing for them especially on first symptoms. It was common for them to describe their own self neglect along with a lack of insight into their symptoms and illness. Being in denial about their symptoms and wanting to wait and see if they would subside without seeking help.

One of the problems was a lack of insight and awareness of mental illness particularly at the first episode of illness. Participants were often confused about their initial symptoms and unsure where to turn for help. The most usual reaction participants had was to keep their illness and symptoms to themselves, to become more isolated from friends, family, social networks and services, and for their mental health to deteriorate.

Some participants described using cannabis at this time to take the edge off their symptom; they were, *"smoking to feel normal"* unaware that this might be detrimental to their longer term mental health. Substance misuse could also interfere with their ability to truly recognise their experiences as genuine symptoms.

At their first symptoms, none of the participants realised they were experiencing a mental health problem. Some participants recognised that they might have been behaving differently, for example involving aggression or experiencing hallucinations, but none associated their change in attitude, behaviour or feelings with the concept of experiencing a mental health problem.

Some participants felt they were experiencing a spiritual encounter but only one sought support from a faith leader. There were in fact mixed feeling about approaching the faith

sector at this early stage. The support from the faith sector could be very variable; some might offer consolation or prayer, however others might be afraid of the men's symptoms or reject them outright. Some men were themselves fearful that the faith leaders might report them to services.

1.4 Family and Friends

Participants described family and friends as being the people who would most likely recognise if they were experiencing a mental health problem. Fear about how the community may respond prevented some participants from approaching their friends and telling them about their symptoms. But when they did approach family and friends the help they received was also variable.

Families often lacked awareness and might react by telling them to 'pull themselves together', in another example family member's told the participant to just 'get on with things' which conjured up an image of denial and ties in with the expectation that black men live up to the stereotype of being strong. The point was also made that certain 'Black cultures' may be more likely to may want to support the person within the family rather than depend on statutory services.

Overall the one characteristic that families and participants shared was a lack of language, awareness and insight about mental health problems and not knowing how to react when someone is experiencing these symptoms.

On occasions some participants had friends or family members with a professional background in healthcare, who were confident enough in their knowledge of the system to be able to insist that they received treatment. However this appeared to be the exception with the majority of participants being introduced to mental health services during a crisis and more often being suddenly taken into care against their will.

1.5 Contact with services - crisis

"you just hit a brick wall rock bottom or the police"

Although a few participants saw their GP when they had their first symptoms (often initiated by a family member) most participants only realised they were experiencing a mental health problem following contact with statutory services: police, courts, prison or secure care.

For one participant it was the judge who raised concerns about his mental state. However as with several participants he was only referred to secure care after he had been detained in prison and had significantly deteriorated his health.

Following their index offence, the contact participants had with services generally involved abrupt confrontation. Harsh treatment was seen as 'part-and-parcel' of contact with statutory support, which was linked to feelings of being mistreated by police or difficulties within a prison establishment.

1.6 Biased Decision-Making:

Participants often felt that there was unfair discrimination within the system. The described being mis-represented in police report forms and often, incorrectly described as violent in police reports which were used to inform later assessments. On one occasion a participant described how he felt police reports had portrayed him as being dangerous and intimidating. But the context was that he had called them for help as he was scared, thought he was going to die and had nowhere else to turn. The participant explained that he was held down with unnecessary force and believed that the reports were informed by racial bias. Participants felt that these reports could reproduce stereotypes of Black men which are then perpetuated throughout their journey through secure care.

1.7 Assessment

When participants enter secure care they often experience fear and feelings of being misunderstood. Consequently, instead of being a point of respite this stage in the journey compounded pre-existing levels of resentment for participants.

Too fast and too hostile: Participants often described themselves on their journey through secure care as if they were passengers with little or no opportunity to change the direction of the journey or to express their needs, interests or concerns. This feeling of powerlessness often commenced with their index offence and became consolidated upon assessment. Participants stressed that this was a key point in their life when they needed time and space to think. They also mentioned that they needed someone to talk to who could empathise with them.

At the same time they wanted help from people who would be engaging with them, making decisions about them and to have some acceptance of the multiple difficulties they had faced. Contrastingly however participant's recollection of this part of the process was one of speed and tension

1.8 Needing insight

At this point early on in the journey many participants spoke about the importance of insight into what they are experiencing. They felt this insight was helpful and should be an educative element that takes places at the earliest possible stage. This was discussed at different points as a way of helping participants to be able to view recovery. Additionally, a common theme was the impression that people making decisions did not consider or could never relate to the difficult social experiences that the participants had experienced. It was also suggested that only limited attempts were ever made to understand participants backgrounds or too appreciate that the confusion and anger they displayed might be completely justified in the context.

Apprehension: The majority of participants talked about not feeling safe upon entering secure care. Their initial encounter was marked by strong and overriding emotions of fear. This was embedded in thoughts about concerns of losing liberty, the effect of medication such as the ability to communicate socially and losing sexual function.

1.9 Role of individuals and agencies

Before admission

	Negative impact	Positive impact
Family friends	May ignore symptoms May be unsure how to react and give unhelpful advice Just be strong get on with it Physical abuse, harsh upbringing	Often be the first to illness or were approached in times of crisis Can alert services
Employers	Needing work, not being able to work, having had work and losing it because of illness. .	May notice symptoms
GP, Doctor	May not catch symptoms early enough. Not take patients seriously May wait until crisis point	Early intervention can prevent admission
CJS Police, probation, courts)	Crisis heavy system. Often in the context of emergency or following an incident. Fear and mistrust	Can pick up vulnerable men and divert to treatment.
Faith sector, Priest, Iman, Pastor	Religious texts could be a source of anxiety May be told to pray Religion can be a source of negative self judgement.	Priests and imams could provide advice and signposting
Voluntary faith, NGO sector	Internal divisions / factions not helpful for participants	Support network & social capital Can provide a framework for support

2. Inpatient experience

A common theme was that participants generally did not want to be in secure care and doubted the benefit they were gaining from their time there. There were mixed views about whether time in prison or secure care was preferable. Some participants felt that a sentence in prison wold be concluded much more quickly than time in secure care, but a few did describe hospital as a much more positive environment than prison. Some examples of good patient care were shared, but a recurring theme being uneasy in an institution they believed was often unfair and discriminatory.

2.1 interactions with staff

There were wide-ranging thoughts expressed regarding the functions of different staff and how each interacts with patients. This included the desire to spend more time interacting with senior staff as it was felt they could influence important decisions. But participants felt that this interaction was very limited and doctors had restricted knowledge about the participants.

In some settings there was tension between staff and the participants. One participant described how his sentimental items had been stolen from his room but he received an inadequate response from staff. Another made repeated requests to speak with an Imam but staff never replied to his request.

Nevertheless, there was also strong appreciation for nurses and support workers. On several occasions participants praised individual staff that went out of their way to support patients for example by arranging social outings. Another participant acknowledged that a staff member had taking into account his Rastafarian cultural preferences.

A further point raised was access to staff with appropriate skills, in particular staff with substance misuse expertise. One patient had made requests for help with his addiction but was not provided with sufficiently skilled staff to support him.

Another area of concern was ward nurses in some secure settings whom did not act as if they were qualified to carry out a role which involves caring responsibilities. One participant described how a member of staff only spoke to him briefly in bursts of 'Black slang', this contrasted with the longer conversations the staff member had with other patients. He pointed out that this limited his opportunities to communicate and socialise.

2.2 Staff ethnic dynamic

The participants were conscious of the ethnic breakdown of staff in different roles. They called for a cross section of society to be represented in the staff however they described clear ethnic divisions with senior staff being white and occasionally Asian but nursing staff nursing staff more often described as African.

There seemed to be a complex dynamic with African nursing staff in particular who were portrayed as being employed by people in authority to physically hold down the men in care.

> *"They use all these big, strong African males to hold you down, they hold your head down, they embarrass you by pulling down your trousers so your bum pops out, they put their knee in the back of your neck, holding your head and put an injection of liquid in you and you don't even know what that liquid is."*

There was a perception that some of these nursing staff could be authoritarian and very strict towards the participants which they directly attributed to having been trained abroad where attitudes were thought to be less sympathetic.

> *"they have a third world attitude you got yourself into this situation you get yourself out of it"*

This sentiment was agreed by other participants who indicated that some African staff could be less compassionate when relating with patients.

2.3   Medication

The decisions made about the type and quantity of medication that patients receive emerged as significant theme. On the positive side some participants described that their first realisation of being unwell was after they were first given medication which helped them gained an insight into their symptoms.

However the men often had strong opinions about the types of medication, the administration method and dosage they were given. Some questioned if their diagnosis and medication might have been incorrectly influenced by stereotypes about Black men being big and dangerous. A persistent theme was that they were being given higher dosages or stronger medications than their white peers.

Participants also described their struggle to remain on medications with fewer side effects. They were anxious about not being alert and not being able to function socially and this was one of the reasons given for wanting to skip taking medication. One case involved a man who continued to have unwanted and severe side-effects involving spasms and the sensation of his eyes rolling back as a result of the medication he was given. Eventually his medication was changed which allowed him to progress, but later a decision was made to put him back on the original medication which resulted in a violent interaction.

Again the decisions about medication pinpointed another juncture where participants felt they were not being consulted or heard. Participants wanted to be involved in the choice of treatment and were especially suspicious of if they were forcibly injected with unknown substances to sedate them following an altercation.

One of the suggestions was that drug free trials should be available to secure service users, so that the side effects and symptoms could be monitored

2.4 Violence and abuse

A number of examples were given of unfairness across the system which have been described regarding medication, risk assessments etc. Participants also reported physical violence against patients at various stages in the journey. There described altercations between staff and patients and accounts of how patients came together to protect themselves to fight with ward staff.

Collective concerns were raised about the unnecessary use of force when dealing with Black patients. Furthermore, stories were shared about the conditions patients encountered when in seclusion. This included being undressed and exposed to very cold temperatures as what was thought was an over-zealous form of punishment.

There were descriptions of being beaten up before entering the police station, as well as being victims of violence within secure care. Racist abuse of staff by other patients appeared to be tolerated, which was a double standard which participants could not accept.

Participants related many experiences where they felt that their views and needs were being overlooked. This ranged from recreations issues such as the reduced use of communal spaces to having a say in joint decision making about their on-going treatment.

They also highlighted instances of unequal and unfair treatment in a range of decision-making points. Some of these points occur frequently, such as the decision to treat a patient with compassion, whereas others are less frequent and include decisions about stepping patients down to a lower risk environment.

2.5 Differential Treatment

A few participants referred to occasions when they felt they were treated differently by staff because they were either; young, male and often black. There was also awareness that black men were kept in secure units for longer than their white counterparts. There were specific examples given white and black people having committed similar violations but the sanctions were more severe for the black patients.

Strong emotions were shared that negative experiences, such as punishment, tribunals, Ministry of Justice decisions about leave, were driven by racial assumptions. Patients spoke about how racism was a normal feature of how secure services operate and decisions are made. In this way, stereotypes, and racial assumptions were seen as informing therapeutic relationships.

2.6 Tribunal:

The overarching feeling presented about the tribunal process is that there are limited opportunities for engagement. Participants felt that the order of deliberations do not appreciate the state of mind they are in and this limits their capacity to do justice to their position. In particular, participants found it difficult to participate in an adversarial system when they were confronted with many reports but did not feel able to counter them alone and immediately. This difficulty was compounded by the use of terminology which participants felt was inaccessible to them.
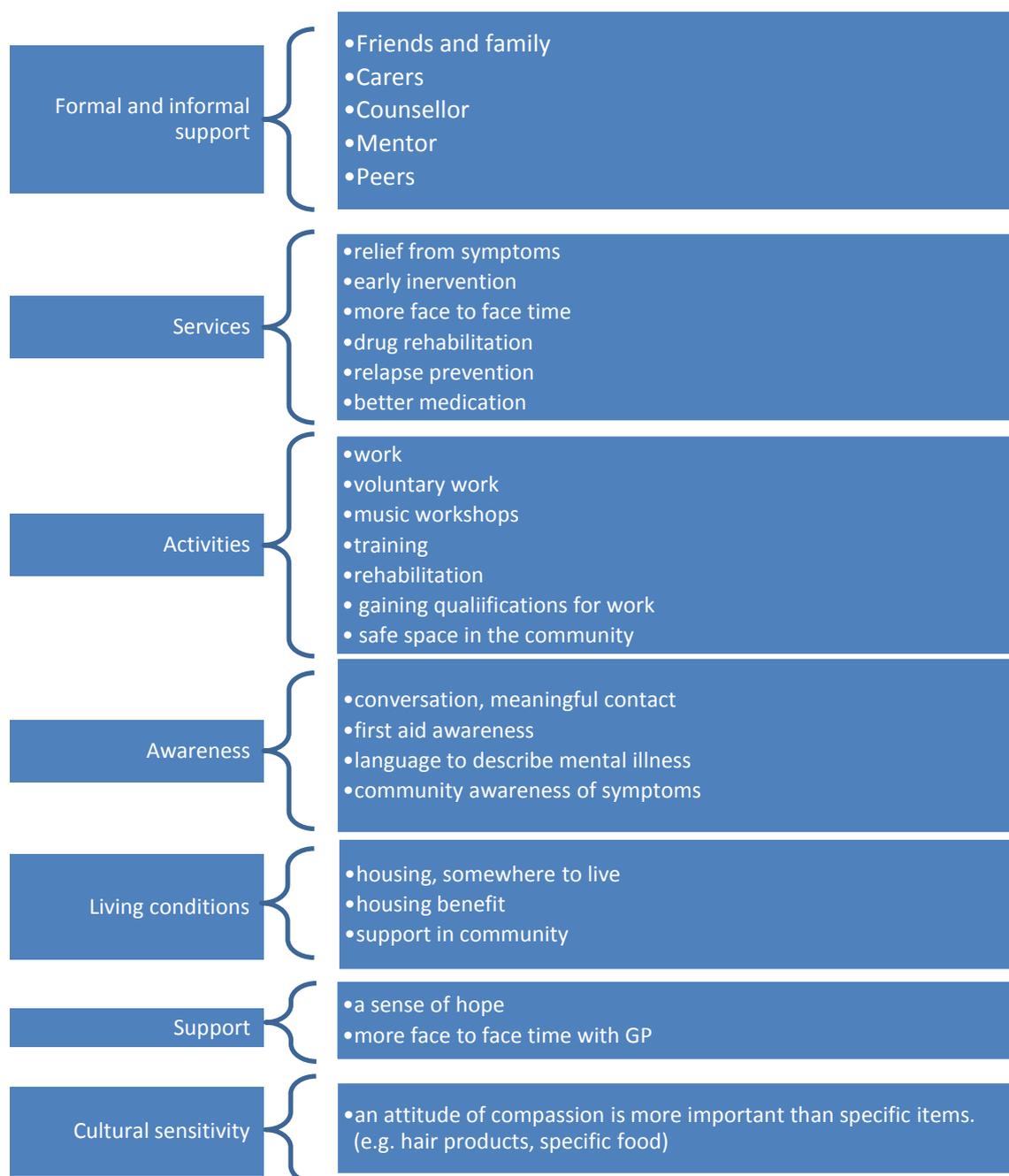
2.7 Role of individuals and agencies

	Negative impact	Positive impact
Family friends	May be interpreted as betrayal If alert services Lack language to talk about mental illness	May hold services to account Possible advocate role
Psychologist, MH nurse. CMHT. ,	Tension with some staff Reliance on strong medication Longer length of stay also conflict Can be authoritarian May be perceived as punitive Staff ethnic dynamic can be difficult. Some cases of unfairness and abise reported	Positive, therapeutic relationship Source of support treatment Some staff were empathetic and valued but often moved on.
CJS	Inequalities Delays to release date and tribunal Tribunals have are unfairly balanced	
Faith sector, Priest, Iman, Pastor	May not be available when requested	Faith sector could be a source of comfort in crisis
Voluntary faith, NGO sector		Can provide training as a source of rehabilitation and preparation to return to the community.

Recovery and Discharge

3.1 Transition to community

Participants described several factors they felt would contribute to their recovery, preparation for discharge and maintaining their wellbeing once they are released. The men needed to be prepared and ready for recovery and they described the main criteria for recovery as having a single minded determination to rebuild their lives. Some men talked about a recovery plan that included volunteering, learning skills, managing illness and temperament, and skills they needed to believe in themselves. These included a supportive social network of family, friends and services and peers who they could turn to for support.

Formal and informal support
- Friends and family
- Carers
- Counsellor
- Mentor
- Peers

Services
- relief from symptoms
- early inervention
- more face to face time
- drug rehabilitation
- relapse prevention
- better medication

Activities
- work
- voluntary work
- music workshops
- training
- rehabilitation
- gaining qualiifications for work
- safe space in the community

Awareness
- conversation, meaningful contact
- first aid awareness
- language to describe mental illness
- community awareness of symptoms

Living conditions
- housing, somewhere to live
- housing benefit
- support in community

Support
- a sense of hope
- more face to face time with GP

Cultural sensitivity
- an attitude of compassion is more important than specific items. (e.g. hair products, specific food)

3.2 A supportive safe environment:

One of the key issues that was mentioned as key to recovery was the need for an empathetic relationship with Drs, psychologists and nurses that saw them as individuals rather than through an index offence or negative stereotypes.

This included: not being overly sedated so they can talk to people, being introduced to relevant services and maintaining a degree of contact with positive relationships that have been established with staff. They described wanting to practicing more relevant scenarios with psychologists that resemble issues that will be encountered back in the community (e.g. remaining calm in hostile situations), stable and hygienic accommodation, vocational training opportunities. This is especially relevant as many participants indicated that they often experienced tensions and lack of trust during their care.

3.3 Housing

Housing was an important part of recovery and resettling into the community. For some it was the central issue, being housed in an area where they were the only black person made them feel vulnerable but they did not necessarily want to be housed in a location they were familiar with if this brought them into contact with negative influences.

3.4 Appropriate care plan:

Participants discussed the need for positive care plans which are negotiated mutually, are flexible and acceptable to all parties rather than being presented with a one sided document; *"it was written and I was told to sign it"*. The plan would include activities that are challenging enough to be useful and would also bring them skills that they wold require when they were released.

3.5 Medication

Participants wanted a more collaborative approach to choosing which drug they were given. They believed they were more often coerced into treatment and more often required to have injections rather than tablets. Being pinned down and injected with an unknown substance was a cause for concern which also aroused suspicion. The men believed they were thought of as more violent so they were more often given injections.

3.6 Training and Work

Opportunity for training and skills acquisition: The learning and maintenance of skills was an important issue. Participants talked about wanting to be employed and occupied once they were released. They gave examples of studying for vocational qualifications and some were involved in voluntary activities in preparation for their release.

3.7 Community safe space

Once in the community participants expressed a strong desire to be able to go to a place where efforts are made to understand their background so that they can feel accepted. This included space to be with peers, the opportunity to take of roles of responsibility, family and home visit and the possibility of a less medical focused environment and space to seek religious support.

Participants talked about a community resource that would support recovery, build up their skills, and provide legal, medical, housing advice. Participants also described the beneficial impact of outreach schemes and community buddy schemes where a regular group of individuals would oversee their recovery and integration into the community. The men also talked about a positive recovery environment in the community which would have facilities for activities such as cooking, learning relaxing and making music.

3.8   Seeing the person

The participants had often pointed out that they wanted to be seen as individuals and to interact with services and community with a sense of empathy and compassion; to be treated rather than punished. A guiding principle therefore was that services should be sensitive to the needs of them individuals.

3.7   Role of individuals and agencies

	Negative impact	Positive impact
Family & friends	If returned to the wrong environment Lack of support in the community If peer groups have risky behaviour could be detrimental.	Community involved in support and rehabilitation Continuity support was inconsistent
Employers		Work and skills contribute to recovery. Prepared to take any work,
GP, Doctor CMHT.	If medication is too strong which renders them unable to relate to people	Community care continuity and good relationships were essential
CJS, (Police, probation, courts)		Probation providing support for seeking employment
Voluntary faith, NGO sector	In fighting between agencies can reduce the support which is available	A community resource Positive activities in the community. Volunteering and building skills Training as a source of rehabilitation Participants talk about the voluntary work they had done or would like to do as an ongoing support.

Cross cutting issues

The above has described the pathway through the secure care more or less as a time line from first symptoms through their time in secure care and through to their recovery and discharge.

Throughout that time line there are important issues which recur and which need to be separated so that they can be appreciated. .One of the most common issue is the lack of knowledge on the part of participants, family and services which are detrimental to the men which seems to run through the data. This is followed by issues of lack of trust which individuals show but on the part of services becomes framed as risk. Lastly a common issue is that of stereotyping which fill in gaps in knowledge and is a component of trust and risk assessment.

1. Knowledge
2. Trust and Risk.
3. Stereotyping

Lack of knowledge

One important theme which runs through the accounts is that of 'knowledge'. There are repeated references to 'knowledge' or lack of knowledge about symptoms, services, individual relationships and treatment throughout the accounts at almost every stage of the journey. At the start of the pathway when participants first became unwell they lacked knowledge and awareness about mental illness and did not understand what their early symptoms indicated.

The participants also talked about their lack of knowledge about the services available and not knowing who they could turn to for help. In addition they also described how friends and family also did not know which services to access. It seemed that the combination of this lack of knowledge between the participants, their friends and family contributed to their deterioration, self-neglect, isolation and eventually to crisis and intervention by the police. Once they were in the system their lack of knowledge lead them to be y were unable to articulate their needs and so were less likely to access the most appropriate services or be able to negotiate with them to have the most positive outcomes.

The lack of knowledge on the part of participants seemed to be repeated by services that were believed to be influenced by stereotypes more than knowledge of the individual and their symptoms.

The pattern was repeated for the men once they were in care with staff who reportedly *"don't know how to relate to black men in care"* or don't know how to react to participants' anger, which is itself often rooted in frustration driven by not knowing how to respond to their situation, with the results that they are given harsher sanctions.

As well as not knowing how to relate to service participants also described not knowing or being consulted in their treatment. At the most extreme example was being forcibly sedated

as there was no opportunity to plan or consent to medication in extreme circumstances. But for many participants there was added anxiety about not knowing what their treatment was or who they were being treated by.   The lack of knowledge about the mental illness, services, treatment, assessment and criminal justice, not only causes distress for participants but also can contribute to longer lengths of stay.

Trust and Risk

The idea of trust was often mentioned by participants across the journey through secure services. The men were often apprehensive about services and often delayed confiding in trust friends, family or primary care because they did not feel able to trust them. Very often the men talked about not being able to trust people who are close to them and would normally be expected to be a source of support. The following are typical, *"I wouldn't trust my family", "I didn't feel safe to trust the teachers". "you can't trust anybody". "I didn't trust the church"*

One of the common characteristics was for people to isolate themselves when they became unwell. This was often made worse by paranoia with the effect that the symptoms they are experiencing also contribute to their isolation and keeps them away from seeking help
The lack of trust seemed to increase the tendency for the men to become more isolated when their symptoms emerged, and more withdrawn at work or with their friends. At the same time the men would often seek relief from symptoms by using cannabis or alcohol, which would often worsen their symptoms, increase the paranoia and to intensify the negative outcomes.

The situation is made more difficult if the men had sought help, and had then been taken into care with some force. Being forcibly taken into care after approaching a service or family member was specifically referred to as a breach of trust. So these men are caught between their fear of services and betrayal if they are taken into care against their wishes having believed that they would remain in the community.

Services need to be able to rebuild trust with the men in their care, participants pointed out that could be achieved but that it was unusual and required an investment of time by staff which they often could not spare.

> *"I've had numerous counselling and psychologists. I've not stuck at them because the trust part of me is really bad. There was only one I built a trust with and she has now gone …"*

The lack of trust was to some extent mutual with participants indicating that that services often did not trust them. But when trust is applied towards participants it becomes reframed as 'risk' and quantified through risk assessments which, as described above, tended to be more restrictive with black service users than their white peers. Participants felt that the combined lack of trust and stereotyping resulted in Black people being required to *"jump through more hoops"* when for example their risk for unescorted leave was being assessed. Drs would take calculated risks with patient allowing them to go into a less restrictive settings but participants believed that this was seen less often with black patients who tended to have longer stays and a more cautious approach to care.

Image of black men / stereotyping.

Stereotypical images of young black men were a recurring theme in the group discussions. Participants were aware of two sides to this stereotype, on the one hand negative stereotypes of black men could be applied to them in a detrimental manner, but there was also a concern that others may adopt and internalise negative stereotypes because they were familiar with them and they did feel the alternative were open to them.

There was a perception that young men in general could be boisterous and defiant. Participants talked of living life *"fearlessly", "soldiering"* and challenging the struggles and perceived unfairness they faced in their daily situation. Some participants identified with this image or remembered an element of it from their youth. However others did not want a crude stereotype to be unfairly applied to them. They gave examples of young black men being portrayed as aggressive and this stereotype being used to justify harsher treatment, more physical restraints, more powerful and larger doses of sedatives and longer sentences.

A number had been reprimanded for innocuous activities because they were perceived as appearing to be threatening even if they had not actually committed any offence. The perception of black men being, louder, more aggressive, confrontational, intimidating, being *"big, black and dangerous"* was quoted as a reason why they seemed to have harsher treatment, more seclusion, longer sentences, more restraint, stronger medication, higher doses and more often medicated against their will. One participant described that he was reprimanded after looking through a window because stature, gender and skin colour were perceived to be intimidating.

They did feel as if they were negatively stereotyped, any challenge to authority would be interpreted as intimidating. This in itself was a further source of frustration as they felt unable to express dissatisfaction vocally for fear of that this would be interpreted as being threatening and lead to punishment.

When asked what could be done to tackle this situation a common response was that the men wanted staff to take time to know them so that they could build an understanding and so be treated with compassion and empathy.

Participants indicated that preparation to re-join the community should include tackling roots of the perception of black men as dangerous and learning to challenge authority in a way that is not perceived as intimidating. They also wanted to encourage empathy among staff so that they would see them as human beings, converse with them normally. De-escalation skills for staff are needed, so that restraint was used less frequently.