Ethnic differences in coercive interventions and its influence on help-seeking behaviours among Black first episode psychosis patients

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Contribution of Authors

The present thesis was written by Sommer Knight and reviewed by Drs. G. Eric Jarvis and Andrew G. Ryder. Sommer Knight conceptualized the project, performed the literature review, collected the data and analyzed findings on her own. Statistical analyses were performed and interpreted in collaboration with Dr. Ryder. The thesis was externally reviewed by Dr. Kelly Anderson.

Abstract

Past studies have shown that there is differential treatment in psychiatric care among ethnicities. Previous literature in the United Kingdom and United States shows that Black patients are disproportionately diagnosed with schizophrenia or psychosis and are more likely to be involuntarily admitted to psychiatric hospitals. Whether these findings may also hold true in Canada, and how these experiences may have influenced Black patient attitudes towards mental health services are poorly understood. Using a mixed-methods design, the objectives of this study are: 1) to determine whether Black first episode psychosis (FEP) patients are at a higher risk of coercive referral and coercive intervention than non-Black FEP patients, 2) to examine the experiences of Black FEP patients who underwent coercive interventions, and 3) to explore how these experiences may have influenced help-seeking behaviours. Retrospective data from patients referred to a First-Episode Psychosis program from 2015-2018 was collected via chart review ($N = 279$). A sample of five English-speaking male FEP patients, who self-identify as Black, and are still actively being followed by FEPP were recruited for the study. Participants were interviewed and asked a series of open-ended questions related to their treatment experience for psychosis. Chi-square tests explored the relationship between ethnicity, diagnosis of psychosis and coercive intervention. Thematic analysis guided the analysis of the qualitative data. Results showed that Black FEP patients are significantly more likely to be coercively referred ($\chi^2 = 9.25$, df = 2, $p = .01$) and coercively treated ($\chi^2 = 9.21$, df = 2, $p = .01$) than non-Black FEP patients. The patients also reported that they perceived *loneliness, feeling unheard, police contact* and *forced medication* as contributing to reduced help-seeking behaviours. Information from this study can be used to improve clinical interventions and triage procedures so patients can participate in treatment decisions. The study can also be used to inform policymakers and hospital administration how to promote patient welfare and autonomy in clinical settings.

Résumé

Des études antérieures ont montré que les traitements en soins psychiatriques diffèrent selon les ethnies. Au Royaume-Uni et aux États-Unis, les écrits rapportent que les patients noirs reçoivent un diagnostic de schizophrénie ou de psychose de manière disproportionnée et sont plus susceptibles d’admission involontaire dans des hôpitaux psychiatriques. On comprend encore mal si ces observations peuvent également être vérifiées au Canada et comment ces expériences ont pu influencer l'attitude des patients noirs à l'égard des services de santé mentale. Les objectifs de cette étude utilisant une approche de méthodes mixtes sont de: 1) déterminer si les patients noirs atteints du premier épisode de psychose (PEP) sont plus à risque de prise en charge et d'intervention sans consentement que les patients PEP non noirs; 2) examiner les expériences des patients PEP noirs qui ont été soumis à un traitement obligatoire, et 3) explorer comment ces expériences peuvent avoir influencé les comportements de recherche d'aide. On a recueilli les données rétrospectives des patients référés à un programme du premier épisode de psychose (PPEP) de 2015 à 2018 par un examen des dossiers (N = 279). Un échantillon de cinq patients PEP anglophones de sexe masculin, qui s'identifient eux-mêmes comme Noirs et qui sont toujours activement suivis par le PPEP, ont été recrutés pour l'étude. Les patients recrutés ont participé à une entrevue et ont répondu à une série de questions ouvertes concernant leur expérience de traitement de la psychose. Les tests du chi carré ont mis en relation l'ethnicité, le diagnostic de psychose et le traitement obligatoire. Une analyse thématique a guidé l'analyse des données qualitatives. Les résultats ont montré que les patients PEP noirs sont significativement plus susceptibles de prise en charge sans consentement (χ^2 = 9,25, df = 2, p = ,01) et de

traitement obligatoire ($\chi^2 = 9{,}21$, df = 2, p = ,01) que les patients PEP non noirs. Selon les patients, la *solitude,* le *sentiment de ne pas être entendu*, les *contacts avec la police* et la *prise de médicaments obligatoire* ont contribué à réduire les comportements de recherche d'aide. Cette étude peut contribuer à l'amélioration des interventions cliniques et des procédures de triage dans le but de faire participer les patients aux décisions de traitement. L'étude peut également servir à informer les décideurs politiques et l'administration hospitalière sur la manière de promouvoir le bien-être et l'autonomie des patients en milieu clinique.

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Coercive intervention measures in psychiatric care are employed to ensure the safety of the patient and other persons (Kallert et al., 2011). However, these interventions suspend individual rights of the patient and often involve forced court ordered treatment, chemical or physical restraints, seclusion and intramuscular antipsychotic use (Tran et al., 2019). Previous literature in the United Kingdom (UK) and United States (US) show that certain racial and ethnic minority groups are at greater risk for coercive treatment (Bhui et al., 2003; Chiu et al., 2016). Whether these findings also hold true in the Canadian context (Anderson, 2015a; Jarvis et al., 2011) is unclear, and even less is known about how these coercive intervention experiences may influence patient attitudes to psychiatric care (Annoual et al., 2007).

The purpose of this study is to determine whether Black first-episode psychosis (FEP) patients are at a higher risk for coercive referral and intervention than non-Black FEP patients. Given the limited research on coercive treatment in Canada, particularly among ethnic minorities **(**Sashidharan et al., 2019; Gooding et al., 2020), this study fills the gap by exploring the experience of black people on their way to hospital admission, and what these pathways to care could mean to members of the Black community. The study also aims to offer insight into the experiences of Black FEP patients who have been coercively treated, and how these experiences may influence help-seeking behaviours and attitudes to psychiatric services. Conclusions drawn from this study will contribute to the literature on Black Canadians, which has heretofore been scarce, and will highlight factors that may place FEP patients at risk for coercive intervention.

Information from this study also offers suggestions on how to improve the treatment of Black patients with early psychosis and promote their well-being.

Literature Review

Coercion refers to the impermissible use of force, threats, or other unethical means in order to gain compliance from another person (Bluementhal-Barby, 2012; Szmukler, 2015). Coercion may be used when a person is deemed an imminent danger to themselves or others; however it is often viewed as an unethical act as it compromises individual rights (Kallert et al., 2011). For these reasons, coercive treatment is an ethical and clinical challenge in psychiatry. It is an ethical challenge because it infringes upon patient autonomy and creates moral ambiguity for mental health professionals who are expected to promote patient well-being (Hem et al., 2018; Hem et al., 2014). As well, it is a clinical challenge as coercive interventions are often employed by clinicians to control patients with poor insight into their illness and who refuse medication (Horvath et al., 2018). In theory, these preventative actions are taken to ensure public safety and the well-being of the patient. However, the use of coercive measures during the treatment process may inadvertently lead to adverse health outcomes and negative attitudes to mental health services for patients (Jordan & McNiel, 2020; Tingleff, 2017).

Krieger et al. (2018) found that invasive measures (e.g. physical restraints) were less acceptable to patients than non-invasive measures (e.g., use of seclusion) and most patients experienced negative emotions of helplessness and shame from coercive interventions. Similarly, Mielau and colleagues (2018) found that the lack of fairness and experience with coercion had negatively influenced patients’ attitudes toward psychiatric treatment. These findings also extend to medical staff. In a cross-sectional study conducted by Brega and colleagues (2018), the researchers found that nurses predominantly had negative attitudes toward coercive measures and use of coercion negatively impacted job satisfaction and coping with stress. Hence, the use of coercion negatively affects patients and clinicians and must be used sparingly to minimize harmful consequences to everyone.

Historical and Current Practices of Coercion in Psychiatry

Over the past 20 years, medical coercion has become increasingly studied due to its common use and associated controversies (Sashidharan & Saraceno, 2017). The expansion of collaborative care models and mandated community treatment for patient groups may partially account for growing acceptance of coercive care (Lake & Turner, 2017; Swartz & Swanson, 2020). Settings such as outpatient centers, early intervention programs, long-term care facilities and inpatient wards – where the mentally ill are typically treated – are where coercive practices are commonplace (Bonnie & Monahan, 2005; Castillo et al., 2020).

Since the Middle Ages, those with severe mental illness were stigmatized and believed to be possessed by demons (Forcen & Forcen, 2014; Kroll & Bachrach, 1984). Many were often neglected and placed in unhygienic jails or almshouses with little to no support (Dix, 2006). As a result, people with mental illness experienced widespread abuse and unmet mental health needs for centuries (Jelliffe, 1930; Kroll, 1973). Public psychiatric institutions began in the 1840s with social reformer Dorothea Dix, who advocated for improved living conditions of the mentally ill during the reform movement in the United States (Brown, 1998; Dix, 2006). After 40 years of work, Dix secured government funding for state mental asylums (Brown, 1998). Many psychiatric hospitals were built in Europe during this period (Haug & Rossler, 1999). In these asylums, patients were institutionalized and subjected to coercive interventions (Novella, 2010a). In the 1960s, during the era of deinstitutionalization, many argued for more humane care and greater access to outpatient mental health services for mentally ill persons, which led to the closure of asylums and the development of community-based treatment (Mollica, 1983). However, the expansion of psychiatric services led to a depletion in clinical standards due to insufficient funding and limited staffing (Emerson, 1985; Novella, 2010a). For these reasons, the stability of public mental health services and the safety of the general public and the mentally ill were compromised. This led to new mental health legislation and clinical practices involving new forms of coercion, such as court-ordered treatment, to safeguard public and patient safety (Novella, 2010b).

Many critics question whether patients' rights are compatible with mental health care as laws governing involuntary treatment for mental disorders differ from those with physical disorders (Kallet et al., 2011). The role of the physician must encompass competing priorities, such as promoting cooperation and exercising control (Badre et al., 2019). As well, it is unclear whether new forms of coercive mental health fit properly into existing legal frameworks, with the result that they may not fully protect patient rights (Eaton, 2019; Hotzy et al., 2019).

Today, the overall rate of involuntary admissions and coercive interventions in psychiatric hospitals have increased (Sashidharan & Saraceno, 2017). International studies report that across Europe, involuntary admission rates vary from 21-59%, with the highest rates in Poland, Italy and Greece due to differences in legislation and clinical practice (Kalisova et al., 2014). In

China, involuntary admission rates from 2013 to 2017 increased over time since the first national mental health law went into effect in 2013, reaching a high of 87.8% 49 months after the new law took effect (Ma et al., 2019). Similarly, in the US, outpatient court-ordered treatment is gaining acceptance (Testa & West, 2010). Data from Canada also suggests that the prevalence of coercive practice is high and rates of involuntary admissions are increasing over time (Lebenbaum et al., 2018; Rodrigues et al., 2019). However, studies show that certain groups, particularly ethnic minorities of African or Caribbean background (Rodrigues et al., 2020; Vinkers et al., 2010), are at greater risk of involuntary admission and this may be due to excessive application of the "danger" criteria for psychiatric commitment in members of these groups (Gordon, 2015; Large et al., 2008; Testa & West, 2010).

Historical and Current Injustices toward Black People in Psychiatry

Psychiatry's legacy of historical injustices towards vulnerable patient groups has led to criticism of its overexertion of control and abuse of power. Such examples include the killing and extermination of the mentally ill during the Nazi era (Burleigh, 1991; Strous, 2006), the compulsory sterilization of those deemed unsuited to reproduce (Dudley & Gale, 2002) and medical experimentation on Black people in the name of scientific advancement (Washington, 2006).

In the 17th to the 19th centuries, during the period of slavery, Black people came to be seen as "less than" and dehumanized by white European settlers (Goff et al., 2008). Based on pseudoscientific assumptions, they were perceived to be intellectually, biological and socially inferior to their white counterparts, which led to racial exploitation and denigration (Mensah, 2002). In the 1851 paper entitled, “Report on the Diseases and Physical Peculiarities of the Negro Race” by Dr. Samuel A. Cartwright, two diseases were identified: “Dysaethesia Aethopica” and “Drapetomania”. “Dysaethesia Aethiopica” refers to a mental disorder of slaves characterized by a lack of response to stimulus, laziness, and a partial stupor in African slaves. Jarvis also describes this condition in 2008. “Drapetomania” refers to an insane state in slaves in which they want to flee their natural state of slavery, also described by Jarvis (2008) and Willoughby (2018). The enslavement of Africans was deemed a therapeutic necessity for the “well-being” of slaves by medical professionals and a clinical responsibility for slave masters to justify slavery (Szasz, 1971). Subsequently, the medical belief that Black people were inferior to White Europeans persisted in the 1930s leading to the infamous Tuskegee Syphilis Study in which 399 African American men were experimented on for 40 years to learn about the natural course of the Syphilis disease (Washington, 2006). They were not given treatment even when treatments came available and were subjected to unauthorized dissections due to racist pseudoscience (Washington, 2006). The historical medical mistreatment of Black people has negatively influenced public attitudes to healthcare today. Recent studies show that Black people have negative attitudes towards psychiatric medication and a general unwillingness to take part in any form of genetic research or pharmaceutical treatment (Braunstein et al., 2008; Murphy & Thompson, 2009). The abuses of the past may have engendered cultural and racial mistrust towards mental health professionals within the Black community today (Jaiswal & Halkitis, 2019; Jaiswal, 2019).

After slavery ended in the United States, there was still racial injustice pervasive in schools, employment and other institutional spheres, which led to the Civil Rights movement and institutional reform (Bloom, 2019). During this time, the field of psychiatry had significantly developed and state psychiatric hospitals were developed to care for the mentally ill. However, mainstream media informed public opinion and Black people were being portrayed as violent criminals due to the riots that took place in the fight for equality (Brasell, 2004; Jacobs & Jacobs, 2000). These events not only influenced the general public but also clinician attitudes and reinforced old biases towards Black people. Due to the social influence of the Civil Rights movement and evolving concepts of major psychiatric disorders, schizophrenia became a racialized illness equated with African-American men in particular (Metzl, 2010), a stereotype that had been in place since before the Civil War (Jarvis, 2008). Many Black people were detained in mental health asylums and labelled “paranoid, hostile and violent” for “disturbing the peace” despite their cry for freedom and equality among their white counterparts (Fernando, 2017). A diagnosis of schizophrenia promised a long-term hospitalization and became associated with “Black rage” (Grier & Cobbs, 2000). In the Ionia State Hospital for the Criminally Insane at the time of the Civil Rights era, charts of patients showed that 88% of African Americans (94% were men) diagnosed with schizophrenia were described as hostile and violent, compared to 44.6% of their white counterparts (Metzl, 2010).

Today, Black people continue to be the face of criminality (Kleider-Offut et al., 2017; Kleider et al., 2012). This is demonstrated by the over-policing of Black lives, the over-representation of Black people in the criminal justice system, and ongoing racial profiling (Hinton et al., 2018; Plant & Peruche, 2005; Smiley & Fakunle, 2016). These social and historical trends have inspired the Black Lives Matter movement (Taylor, 2016).

Due to these negative stereotypes, Black people are associated with violence, with implications for medical and legal institutions in which diagnoses seen as severe can place individuals under confinement based on the criterion of “danger” (Mears et al., 2019; Oliver & Fonash, 2002; Verbrugghe & Vandenberghe, 2008). International studies report that those of African or Caribbean descent are at greater risk of police referral (Archie et al., 2010), involuntary hospital admission (Barnett et al, 2019; Gajwani et al., 2016), and diagnosis of psychosis (Byrne et al., 2019; Paksarian et al., 2016).

Many perceive Canada to be an egalitarian nation free of racial tension and intrinsic prejudice. However, Black Canadians were subjected to slavery, and the lack of attention paid to Canada’s historical treatment of Black people demonstrates far-reaching ignorance and denial by Canadian institutions and individuals, as the country has yet to address the implicit and explicit racism that exists (Maynard, 2017). Slavery was economically important and played a significant role in the Canadian labour system due to the cheap cost of labour and profits for slave owners (Mensah, 2002). Canadian figures who owned slaves included: Francois Baby and John McDonell, who were members of the first Canadian parliament, James McGill, founder of McGill University, Father Louis Payet, the priest of Sainte-Antoine-sur-Richelieu, and Colonel Walter Patterson who was a maritime loyalist (Henry, 2016). Vic Satzewich (1998) states: “one of our most enduring Canadian national myths is that there is less racism here in the US” (p. 11).

Black Canadians

In this study, the operational definition of “Black Canadians” denotes people of African descent in Canada and include the following major subgroups: (1) Canadian-born descendants of

Africans who were relocated due to the slave trade; (2) descendants of Black settlers, loyalists, refugees, and fugitives who immigrated during the American civil war; and (3) those who immigrated post World War 2 from the Caribbean islands or Africa and their descendants (Mensah, 2002). In the 1960s, Canada became more lenient with respect to immigration and the number and diversity of immigrants entering the country grew, leading to its multicultural mosaic today (Kelley & Trebilcock, 1998). Black people were invited to work hard, laborious jobs to gain full acceptance to Canadian society, but were swiftly dismissed when their employment took opportunities from white Canadians (Mensah, 2002). Hartman (1997) refers to this as modern racism due to the "wedding of equality and exclusion in the liberal state" (p.10), in which the state promised equality, but exclusion occurred in practice.

Currently, Black people are still subjected to state discrimination in all institutional spheres in Canadian society (Davids & Fang, 2020; Maynard, 2017). These systemic inequalities are demonstrated in Canadian employment (Agocs & Jain, 2001), immigration laws (Joseph, 2018; Mensah, 2002), the criminal justice system (Wortley & Owusu-Bempah, 2009), public education (Codjoe, 2001), housing, social services (King et al., 2017) and medical institutions (Jarvis et al., 2011). In schools, Black Canadian youth are disproportionately streamed to lower educational levels and are at higher risk of high school dropout (Henry, 2017; Livingstone & Weinfeld, 2017). In child welfare systems, Black children in Toronto represent 41% of the youth in foster care, despite only making up 8.2% of the city's youth population (Contenta et al., 2014). In employment, Black woman have faced significant discrimination due to the texture of their hair, despite no formal hair policies (Brown, 2018). As well, Black teens in Quebec reported being excessively stopped by the police (Dupuis-Deri, 2018), similar to Toronto (Hayle et al., 2016) and Kingston, Ontario (Closs & McKenna, 2006). Due to these realities of anti-blackness across multiple institutions, life in Canada for black people has been equated to living in slavery's "afterlife" (Maynard, 2017).

According to Canadian criminologist Gillian Balfour (2006), medical institutions, social services and immigration departments are considered "non-legal forms of governmentality", because they expose marginalized groups to social control, surveillance and punishment (p. 170). Although, some may assume that racism is strictly an "American problem," racism is also inherent in Canadian institutions and subsequent racist practices, and these public attitudes are embedded in institutional frameworks contributing to the marginalization of Black people in Canada (Austin, 2010). These structural barriers demand institutional reform and examination because racial and ethnic disparities are rooted in social structures and political practices rather than personal attitudes (Allahar 1993; Nelson & Fleras 1995; Satzewich, 1993).

Past research has found that there is little discussion of racism and discrimination in Canada, specifically with respect to Black people (Maynard, 2017; Mensah, 2002; Walker, 1979). Nonetheless ethno-racial status plays a critical role in structuring inequality, and Black Canadians are at the bottom of the social acceptance hierarchy (Berry et al., 1977; Moghaddam et al., 1994; Pineo, 1977). In fact, the Department of Public Safety Canada (2009) found that the historical and contemporary disempowerment of Black community members is similar to those in the Indigenous community, and both groups are over-represented in the criminal justice system (Amadahy & Lawrence, 2009). Hence, it is important to address these prevailing issues plaguing the Black Canadian community (Fanon, 1952; Li 1998; Satzewich & Li, 1987).

Being Black in the Canadian Health Care System

In a Canadian report conducted by Annoual and colleagues (2007), investigators found that: Black Canadians were disproportionately over-represented in involuntary services (e.g., detention centres), and under-represented in voluntary services (e.g., outpatient programs). Members of the Black community are consistently represented at disproportionate rates in these institutions (Maynard, 2017). It is not known if these findings also hold true in psychiatric hospitals in Canada (Anderson, 2015b; Jarvis et al., 2011; Seeman, 2011), wherein patients are involuntarily admitted if they appear to be a danger to themselves or others.

Literature in the UK and US shows that Black patients are disproportionately involuntarily admitted to psychiatric hospitals and committed to outpatient programs (Oduola et al., 2019; Swanson et al., 2009). Researchers in the UK have often attributed differential rates of involuntary hospital admission to racial bias and discrimination (Bennett, 2006; Singh, 2007), whereas researchers in the US believe that discrepant rates of psychosis may be due to cultural barriers and misdiagnosis (Atdijan & Vega, 2005; Brach & Fraserirector, 2000). It is possible that the combination of both diagnostic bias and cumulative effects of discrimination place Black groups, particularly first- and second-generation migrants (Rodrigues et al., 2020), at greater risk of psychosis in addition to coercive interventions. Therefore, it is important to conduct research on the overrepresentation of Black patients in involuntary care and its relation to psychotic disorders. There is little Canadian research on (1) the difference in psychiatric care that Black patients may receive and (2) whether members of the Black community are at greater risk for being involuntarily admitted and coercively treated than other patient groups.

Of the studies available, Canadian researchers found that black patients with psychosis were more likely than members of other groups to have police or ambulance contact prior to Emergency Department presentation (Jarvis et al., 2005), reported more social coercion than members of other immigrant groups (Tran et al., 2019), had less general practitioner involvement (Anderson et al.,2015b), and had poorer follow-up for psychosis in comparison to other patient groups (Anderson, 2018; Nikolitch et al., 2018). Many Black Canadians report feeling unheard by mental health professionals (Woodgate et al., 2017) and dislike the power dynamic between provider and patient based on historical relations (Jarvis, 2012; Medlock et al., 2018). Although other factors have been identified in the underutilization of mental health services by ethnic minorities (George et al., 2015; Woodgate & Busolo, 2018), there is still little research on involuntary admission and coercive treatment in accessing mental health services in Canada, especially among first episode psychosis (FEP) patients (Anderson et al., 2014).

Canadian Studies on Pathways to Care with FEP patients

Prior Canadian studies on ethnic differences in pathways to care and coercive intervention practices, with respect to FEP patients, is mixed. Some studies show that Black FEP patients are more likely to be coercively referred to emergency services via police or ambulance in Toronto (Anderson et al., 2015b; Archie et al., 2010) and Montreal (Jarvis et al., 2005). Whereas other studies show that there are no ethnic differences between negative pathways to care for FEP patients (Rotenberg et al., 2017) and ethnicity did not predict involuntary admission (Rotenburg, Tuck, & McKenzie, 2019). However, Rodrigues and colleagues (2020) found that migrant status and ethnicity were highly related to pathways to care in Ontario, in which first generation African and Caribbean immigrants were more likely to be involuntarily admitted compared to the European group. To add, Anderson (2018) found that African and Caribbean FEP patients were less likely to receive psychiatric follow-up after a hospital admission. These findings suggest that several psychosocial factors play a role in impacting service utilization among ethnic minorities (Anderson, McKenzie, & Kurdyak, 2017; Rotenburg, Tuck & McKenzie, 2017), and it is important to understand the different mechanisms to address disparities in access to care among the FEP population.

Blackness and Psychosis

According the American Psychiatric Association (APA; 2013), psychosis is the symptomatic presentation of one of the following five domains over a 1-month period: delusions (fixed false beliefs), hallucinations (sensory experiences without external stimuli), disorganized speech (loose associations, tangentiality, etc.), abnormal motor behaviour (such as disorganization, catatonic stupor or excitement) and negative symptoms (avolition, diminished expression, etc.). First episode psychosis (FEP) refers to the first experience or reporting of these symptoms by an individual (APA, 2013).

The literature has shown that Black people are significantly more likely to be diagnosed with psychosis or schizophrenia (Qassem et al., 2015; Schwartz & Blankenship, 2014; Strakowski et al., 1996). In fact, in the US, this has been a consistent finding reported from before the Civil War (see Jarvis, 2008), but became more widely known to the general American society since the Civil Rights Movement in which major diagnostic revisions were made (Metzl, 2010). Findings in the US and UK revealed significant racial and ethnic differences in pathways to psychiatric care and involuntary admission among youth experiencing first episode psychosis

(Compton et al., 2006; Weich et al., 2017). Black FEP patients reported greater police involvement (Ajnakina et al., 2017), scored significantly higher on hallucinatory and hostility measures (Oluwoye et al., 2018), and were more likely to be referred by police or ambulance referral than other patient groups (Bhui et al., 2015). Similarly, studies in Canada showed that being Black was significantly associated with reported medical coercion (Tran et al, 2019) and increased likelihood of police contact (Anderson et al., 2014). However, more research is needed to understand the nature of pathways to psychiatric care among Black FEP patients and how aversive pathways may have influenced patient attitudes towards mental health services (Anderson, 2019; Valenti et al., 2014; Wood & Alsawy, 2016).

Limited Research

Most studies about involuntary admission and coercive treatment are quantitative and few studies employ qualitative methodology to obtain a deeper, first person account of patient experiences (Barnes et al., 2000; Gilburt et al., 2008; Priebe et al., 2009). In a systematic review conducted by Katsakou and Priebe (2007), researchers explored psychiatric patients' experiences of perceived coercion from five different qualitative studies. Using thematic analysis, patients from the studies collectively expressed (1) the need for autonomy and participation in treatment decisions, (2) concerns about the quality of care, and (3) the impact of involuntary care on their sense of self-value. However, findings regarding the experience of compulsory treatments are mixed (Jones & Mason, 2002; Priebe et al., 2010; Seed et al., 2016). Some patients viewed involuntary care as a positive experience to maintain their safety and the safety of others (Holmes & Kennedy, 2004; Sibitz et al., 2011); whereas others viewed forced psychiatric treatment as a coercive practice in need of re-evaluation, and that in some cases exacerbated problems (Olofsson & Jacobsson, 2001; Olofsson & Norberg, 2001; Sibitz et al., 2011).

Similarly, in a Canadian study, Ferrari and colleagues (2015) conducted a qualitative study among FEP patients and families to explore causes for differential access to care. Findings revealed that internalized stigma, particularly among the African and Caribbean origin FEP group, plays an important role in service utilization, and that personal awareness of symptoms, family mental health literacy and general knowledge about psychiatric services influenced help-seeking behaviours. More research is needed to explore the experiences of minority FEP patients in the Canadian setting. Thus, this study will evaluate whether these findings hold true in clinical settings from the perspective of Black men with early psychosis.

Hypotheses and Objectives

Using a mixed-methods design, the objectives of the study are:

1) To determine whether Black FEP patients are at a higher risk of coercive referral and coercive intervention to psychiatric services than non-Black FEP patients;
2) To examine the experiences of Black FEP patients who underwent coercive interventions;
3) To explore how these experiences may have influenced help-seeking behaviours.

Based on the literature (Rodrigues et al., 2020; Swanson et al., 2009), we hypothesize that Black FEP patients are at higher risk of coercive referrals and coercive interventions in psychiatric services than non-Black FEP patients. Regarding the qualitative data, we are conducting the qualitative study in an exploratory way where we are interested in both convergence and divergence of participant responses. A mixed-methods approach was selected to strengthen study conclusions about quantitative findings and to provide a more in-depth understanding of the phenomenon being studied in a larger social context (Shorten & Smith, 2017). Of the many types of mixed methods research that are available, this study used an *explanatory sequential design* in which quantitative data preceded the collection of qualitative data, so the qualitative data could illustrate and complement quantitative findings (Harwell, 2011).

Using quantitative methods to assess data retrospectively from patient charts, this study examines the relation between ethnicity and coercive interventions. Using qualitative methods with a prospective sample, this study also explores the experiences of Black FEP patients with their treatment for psychosis with a special focus on those who underwent coercive interventions in a Canadian healthcare setting (in Montreal). Participant interviews shed light on the influence that coercive experiences may have on their help-seeking behaviours and attitudes to mental health services. To date, there is limited data on the experiences of involuntarily admitted patients, specifically among the Black FEP population in Canada. Results of this study address this gap in the clinical and research literature on the coercive experiences of Black patients in medical settings in hopes to improve treatment decisions. This study offers insight into the experiences of involuntarily admitted and coercively referred FEP patients in a Canadian setting. Study findings also provide information on attitudes to care for FEP patients and how coercive intervention measures may influence help-seeking behaviours.

Method

Ethics

The research protocol and consent forms were authorized and approved by the Research Ethics Board of the CIUSSS du Centre-Ouest-de-l'Île de Montréal.

Setting

The First Episode Psychosis Program (FEPP) is located in the Institute of Community and Family Psychiatry of the Jewish General Hospital and has been receiving referrals since 2008. Approximately 40% of the patients are from visible minorities and a considerable proportion are involved in the judicial system

Research Design Overview

An explanatory, sequential, mixed methods research design was used in which elements of qualitative and quantitative research were combined to provide an in-depth analysis of the phenomenon being studied (Levitt et al., 2018; McKim, 2017). A mixed-methods approach was selected to integrate findings from both quantitative and qualitative data to identify ethnic differences in coercive intervention and to explore patient perspectives, as it relates to help-seeking behaviours, to offer further insight on the phenomenon being studied. Quantitative data were collected first via chart review to determine whether Black FEP patients were at higher risk of coercive referral than non-Black FEP patients. Qualitative data were then collected using a phenomenological approach via face-to-face interviews to complement quantitative findings. A phenomenological approach was selected because it provides an in-depth analysis on participants' personal lived experiences. Qualitative data was used to shed light on Black FEP patients' experiences with treatment, uncover when coercion occurred, and determine the influence of coercion, when it occurred, on help-seeking behaviours. An implementation matrix for the study is shown in Figure 1.

Participants

Quantitative Sample

Chart Review. To test the study hypothesis, retrospective data from patients referred to the FEPP from January 14, 2008 to December 31, 2018 were collected via chart review (N = 279), permitting data extraction and analysis on a hospital server using electronic data abstraction forms (see Appendix I).

Inclusion Criteria to FEPP. Inclusion criteria for the study was applied as per clinical routine at the point of entry to the First Episode Psychosis Program (FEPP). Inclusion criteria included: (a) age between 16 and 30 years; (b) treatment with antipsychotic medication for less than 30 days; (c) presence of psychotic symptoms for more than three consecutive days (hallucinations, delusions, paranoid ideation, disorganized speech, thought or behavior, and/or prominent negative symptoms); (d) no severe substance use that could impair participation in the program; (e) no Autism Spectrum Disorder; (f) no Intellectual Disability; (g) no serious medical conditions, such as epilepsy, that could account for the psychotic symptoms; and (h) the patient lives within a 30-minute travel radius of the JGH.

Qualitative Sample

Sample size. A sample of five English-speaking male FEP patients, aged 18-25 at the time of referral, who self-identified as a Black-Canadian, experienced coercive interventions, and were still active to FEPP, and follow-up between January 1, 2019 to December 31, 2019, were recruited to the study. Participants were selected from the FEPP referral database and patient charts were reviewed for selected participants to determine if they experienced any medical or legal coercive measures at the time of referral.

According to the methodological literature for qualitative studies, the sample size should be sufficient to describe the topic being explored and address the research question (Vasileiou et al., 2018). A large sample size such as 20-30 participants may overgeneralize findings and risks yielding repetitive data (Green & Thorogood, 2004). This is a problem as overgeneralization in research limits beliefs to the conclusions drawn by the researcher and does not allow room for other lived experiences which is important in qualitative methods. Saturation occurs when no new information is derived after adding more participants (Hennink & Kaiser, 2019). Thus, a sample of approximately 5-10 participants was estimated for this study to prevent from having additional information that may not necessarily add to the data. This is consistent with past literature; in a review conducted by Katasakou and Priebe (2007), researchers showed that sample sizes ranging from five to ten were fruitful and able to address the research question at hand. However, due to COVID-19 and time constraints, only five FEP patients were interviewed.

Male Focus. Black male FEP patients were recruited to this study instead of Black female FEP patients for several reasons. First, incidence of schizophrenia and first-episode psychosis is higher in male patients than female patients (Di Forti et al., 2015; Ochoa et al., 2012) and there were not enough Black females active in the FEPP program to conduct this study. Second, studies show that male patients are at greater risk for involuntary admission and coercive intervention than females (Hustoft et al., 2013; Riecher et al., 1991; Sampogna et al., 2019; Umama-Agada et al., 2018). Third, when conducting qualitative studies, it is recommended to use a small, homogenous sample (in terms of race, gender, etc.) to describe the in-depth experiences of a subgroup (Patton, 2002). Given these reasons, this study recruited only Black male FEP patients.

Clinical Stability. Clinically stable adults approved by the FEPP clinician were invited to participate in the study. A patient was deemed clinically stable by the FEPP psychiatrist if: 1) the patient can tolerate the interview, 2) symptoms are sufficiently under control, and 3) the patient has the capacity to concentrate, be patient, be reflective and provide coherent answers.

Data Collection

Quantitative Measures

Ethnicity Assignment. The description of ethnicity was extracted from physicians notes in patient hospital files. To determine ethnicity from medical records, participants who were identified as “Black” in their patient chart were grouped together and those who were not identified as black were grouped together. For patients whose ethnicity was not indicated, an ethnicity assignment procedure based on categories from Statistics Canada (2006, 2016) including one’s country of birth, languages spoken, immigration status, and religion and family name were used to determine ethnicity. Statistics Canada (2016) Visible Minority groups included: Aboriginal (Inuit, Metis, North American Indian); South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.); Chinese; Black (e.g., African, Haitian, Jamaican, Somali, etc.); Filipino, Latin American, Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan, etc.); Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.); Korean; Japanese; and Other. Someone who was marked as a multiple visible minority, meaning they were part of two or more minority groups, were categorized under “Mixed.” Those who were mixed or bi-racial, in which one parent was European-origin and the other was from a visible minority, were considered a visible minority as well.

For the purpose of this study, East Asian, South Asian, and Southeast Asian were pooled together under the ethnic/racial category “Asian” to give larger numbers for statistical comparisons. Participants from North Africa (Morocco and Tunisia) were categorized as “Arab”, given the cultural, political, linguistic and religious similarities to countries in the Middle East/West Asia (Halpern, 2015; Hinnebusch, 2015). This procedure resulted in five ethnic groups: White (European descent), Black (Caribbean and African descent), Latinx (Latin American descent), Arab (Middle eastern descent) and Asian (East, South and South-East Asian descent). For purposes of comparison, three patient groups were created from the five ethnic groups: White, Black, and non-Black visible minorities. Non-Black visible minorities included: Arab, Asian and Latinx ethnic groups. These ethnicity assignment procedures were based on Statistics Canada categories (2006, 2016) and has been used by other Canadian studies (Jarvis et al., 2011; Nikolitch et al., 2018; Tran et al., 2019).

Coercive Referral. To determine if patients were coercively referred, hospital charts were reviewed to reveal if patients were brought to emergency services via police, ambulance or court order.

Coercive Intervention. To determine if patients experienced a coercive intervention, legal and medical variables were reviewed (see Table 1).

Legal Coercion. Legal variables included: (a) garde preventive (i.e., preventive confinement completed by a physician); (b) garde provisoire (i.e., temporary confinement for psychiatric assessment rendered by the Court of Quebec); (c) garde en établissement (i.e., confinement in an institution judgement rendered by the Court of Quebec); (d) forced outpatient treatment order (i.e., receive ongoing treatment rendered by the Court of Quebec); (e) tribunal administratif du Québec (TAQ) involvement (i.e., the patient is declared unfit to stand trial or is not criminally responsible and is placed in the follow up of the Tribunal); (f) police contact; (g) other court involvement such as immigration detention (i.e., arrested at border); and youth protection (i.e., Bathshaw, Department of Youth Protection).

Medical Coercion. Medical variables included use of seclusion, physical restraints, code white (show of force) and urgent intra-muscular (IM) antipsychotic.

Qualitative Measures

Socio-demographic Questionnaire. A socio-demographic questionnaire was given to participants to complete in pencil-paper format to provide a description of the sample (Appendix II). Information was collected on participants' age, gender, marital status, country of birth, education level, living conditions and religion. Participants were asked to complete the questionnaire prior to the interview but after informed consent was obtained.

Interview Questions. A series of open-ended questions were posed to each participant. Questions were based on objectives of the present study and in consultation with the advisory committee members. Some questions were adapted from the McGill Illness Narrative Interview (Groleau et al., 2006) and the Cultural Formulation Interview (Lewis-Fernandez et al., 2015) to promote a person-centered approach with consideration of the interviewee's social and cultural context. The interview was structured into six main sections. The purpose of the divisions was to allow the interviewee to share his story in the order that the events occurred from referral, to initial emergency room assessment, to hospital admission and then discharge to outpatient program from the hospital (see Appendix III). The first section asked questions to allow participants to initiate their narrative however they wish (e.g., How were you referred to FEPP?). The second section explored how the participant was admitted to the hospital (e.g., How did you feel about your experience coming to the hospital?). The third section elicited the patient's perception of their treatment during the hospitalization (e.g., How do you feel about the treatment suggested by your doctor?). The fourth section explored whether the participant felt any part of their identity (e.g., race, age, gender, etc.) played a role in their medical care (e.g., What do you think about this statement? *Based on my background or identity, my quality of care is worse*). The fifth section explored the patient attitudes toward mental health services and its influence on help-seeking behaviours (e.g., How has your past experience influenced how you obtain care?). The sixth and last section shed insight into how patients currently feel about their outpatient treatment and what could be improved (e.g., How has your care been so far by the FEPP team?).

Qualitative Procedure

Recruitment. The student researcher was a research assistant in the FEPP program. The student introduced the study to the FEPP clinical team. The student researcher attended weekly FEPP meetings and reminded the psychiatrists and case managers to check if they had any Black FEP patients that could be referred to the study. If a Black FEP patient was deemed suitable for the study and clinically stable by the FEPP psychiatrist and case manager, the case manager introduced the study to the patient. If the patient gave verbal consent to the case manager to participate in the study, the student researcher met with the patient after the next scheduled follow-up appointment. On the day of the interview, the case manager brought the patient to meet the student once the appointment was finished. The student researcher left with the patient to conduct the interview in an office setting.

Reflexivity. The person conducting the interview may have an impact on the type of data collected. Hence, prior to each interview, the position of the student researcher was made transparent. The student shared that she is a 23-year-old, Black-Canadian woman completing her masters at McGill University and has worked as a research assistant at the FEPP since Jan 2019. The student researcher informed participants that she is independent and not involved in the participants' care in anyway. While the researcher acknowledged and, as much as possible, set aside her own beliefs throughout the study, it is possible some unconscious bias was present. To minimize this, semi-structured interview questions were reviewed by the advisory committee members to maintain objectivity and ensure questions were not ambiguous or leading.

Procedure. Interviews took place from January, 2020 to March, 2020. The student researcher explained the study to potential participants and obtained written consent from those who agreed to take part. Participants were informed they had been invited to participate in the study because they were receiving care from the FEPP. Participants were told that the researcher wanted to better understand their experiences in accessing mental health services, and how their experiences may have influenced attitudes, so that care will be improved for future FEP patients. One-time semi-structured interviews were conducted, and participants were asked a series of open-ended questions related to the research questions. All interviews were conducted in an office at the FEPP program and security was notified what room and time the interview was being conducted for safety purposes.

Consent forms were written in plain, simple language and participants were encouraged to ask questions if anything was unclear. Participants were advised that everything mentioned during the interview would be kept confidential, except suicidal or aggressive intent that would require medical intervention. Participants were told that they could withdraw from the study at any time with no consequence to their current treatment. For those who did not wish to be audio-recorded, field notes were taken instead. Out of the five interviews, four were audio-recorded and one involved field notes. Interviews were conducted one-on-one between the researcher and the participant in a private setting and participants were advised to disclose only information they wished to share. The length of interviews varied from 40 to 60 mins and were completed in one session. At the end of the interview, participants were compensated with a $10 gift card and given the research team's contact information.

.Data Analysis

Quantitative Statistical Analysis

Descriptive statistics were calculated for each demographic and study variable using the statistical software JASP 0.9.2 (Love et al., 2019). Chi-square and binary logistic regression analyses explored the relationships among study variables. Chi-square tests were conducted to determine whether the rows and columns of the contingency tables were independent, meaning that an effect was present in which differences in cell frequencies warranted interpretation. Binary logistic regression analyses were conducted to control for predictors (age, gender, ethnicity, violent/threatening behaviour, substance abuse) that could alternative explanations findings for the binary outcome, coercive referral (yes, no). Data analyses was completed by the student researcher in collaboration with the research co-supervisor.

Qualitative Interpretative Phenomenological Analysis

A phenomenological qualitative research design was used to examine the in-depth experience of coercive interventions among Black FEP patients and to explore the potential impact of these experiences on help-seeking behaviours. Interpretative phenomenological analysis (IPA) offers insight into how a given person, in each context, makes sense of complex and subjective phenomena (Smith & Osborn, 2008). This type of qualitative analysis focuses on the way an individual understands and describes their experience and allows the researcher to interpret how the individual makes sense of phenomena in a larger societal context (Smith et al., 2009). Given that this form of analysis focuses on the personal *lived experiences* of participants rather than an objective outcome (Eatough & Smith, 2008), this detailed, in-depth approach was selected to identify themes related to the study research questions.

This approach often involves the use of semi-structured or unstructured interview questions and aims to make sense of the personal and social world of the participant. Doing so is especially important for this study as it focuses on the experiences of members of the Black community who have a documented history of poor experiences with the healthcare system and consistent reports of unmet needs by primary care providers. There are also differences in how members of the Black community experience their “Blackness”, varying from being of mixed heritage, or being native versus foreign born. As well, there are significant differences in the types of coercive intervention each participant experienced and how they made sense of the events that took place. This in-depth analysis is ideal for smaller sample sizes (Smith et al., 2009) and for these reasons, IPA was selected to analyze the qualitative data for this study.

Mixed-Methods Analysis

Findings from both quantitative data and qualitative data were “mixed” and connected in an explanatory sequential design, in which quantitative data preceded the collection of qualitative data, so the qualitative data could illustrate quantitative findings. Results from retrospective chart reviews was used to address the first study objective of whether Black FEP patients are at higher risk of coercive referral and coercive intervention. Results from semi structured interviews was used to address the second and third study objective of eliciting the experiences of coercion among Black FEP patients and the influence of these events on help-seeking behaviours.

Analytic Strategy

Qualitative Process

Interviews were transcribed, coded with a pseudonym, and analyzed by the student researcher. Table 2 shows the analytic process and phases of IPA used for this study as described by Smith and Shinebourne (2012). Interviews were examined individually and then compared across cases. The first phase involved familiarization, in which interview transcripts were read line-by-line and reviewed numerous times by the researcher to identify meaningful statements. The second phase involved extraction, in which meaningful statements were extracted and transformed into emergent themes. The third phase, called clustering, involved grouping emergent themes derived from the transcripts and comparing and clustering them into two categories: major and minor. Themes were judged to be “core” if they represented central elements in all the patient narratives, and “peripheral” if they were present in some but not all of the narratives but nonetheless were conceptually vital as they related to the study aims. The fourth phase involved forming a summary table of themes that were illustrated using relevant extracts from the transcripts. The fifth and last phase involved the write-up in which a cohesive narrative account was written using select extracts to illustrate each theme addressing the study objectives.

Methodological Integrity

To ensure study findings were warranted and upheld methodological integrity, several measures were taken. First, interview questions were objectively reviewed by committee members to reduce potential bias and capture diversity within the study sample. Second, the student researcher, to the best of their ability, tried to limit their influence throughout the study to ensure that treatment narratives came entirely from the individual participant. The student researcher engaged in reflexivity by taking into consideration how their professional and cultural identity can influence data collection and purposefully only asked open-ended questions to not introduce bias during interviews. Third, themes that emerged from the interview transcripts were grounded in evidence using excerpts so findings were derived specifically from the participants' experiences. Fourth, member-checking was performed in which information provided from participants at the end of the interview was confirmed to obtain participant validation and to check for accuracy (Birt et al., 2016). Similarly, the research supervisor and other committee members looked over identified themes to enhance credibility of the results.

Results

Chart Review

Of the 279 chart reviews, 67 were removed for missing data (*n* = 18), lost medical record numbers (*n* = 24), no psychiatry related charts at the time of referral (*n* = 24) or duplication (*n* = 1). Four additional subjects were removed because they were not indicated in the chart, resulting in a total of 208 participants. This may be due to larger administrative reasons or database maintenance in which the reason for the lost FEPP referrals was not noted.

Table 3 summarizes the characteristics of the 208 patients referred to the FEPP. The mean age at referral was 22.87 years old with a standard deviation of 4.51 years. The oldest patient was 40 years old and the youngest patient referred to the FEPP was 16 years old. Of the 208 FEP patients, 96 (46.2%) were white, 42 (20.2%) were Black and 70 (33.6 %) were non-Black visible minorities. Over two-thirds of the sample were male and the majority (91.8%) were single.

Chi-square Results

Chi-square analyses revealed that Black FEP patients had a greater incidence of being coercively referred (observed = 21, expected = 13) than would be expected by chance alone ($\chi^2 = 9.25$, df = 2, $p = .01$). While white FEP patients had lesser incidence (observed = 23, expected = 31; see Table 4). Other important findings showed that Black FEP patients were significantly more likely to experience any coercive intervention involving medical and legal measures (observed = 34, expected = 25; $\chi^2 = 9.21$, df = 2, $p = .01$), whereas FEP patients who were white (observed = 54, expected = 58) or non-Black visible minorities (observed = 38, expected = 42) were less likely (See Table 7). Although the levels of medical coercive intervention were not differentially distributed among FEP patients (see Table 6), Black FEP patients were significantly more likely to experience legal coercive interventions (observed = 34, expected = 24; $\chi^2 = 10.92$, df = 2, $p = .004$) than white FEP patients (observed = 52, expected = 56) and non-Black visible minority FEP patients (observed =36, expected = 41; see Table 5).

Logistic Regression Results

Table 8 displays the results of logistic regression analyses, with coercive referral to emergency services (yes or no) via police, ambulance or court order as the dependent variable. Age, gender, ethnic group, presence of violent or threatening behaviour, and presence of substance abuse were the control variables. For the regression models, the Black patient group was compared to both a white and non-Black minority reference group as a factor variable. Logistic regression models showed that those who were older ($p = .025$, OR = 1.09, 95% CI: 1.01-1.17) and perceived to be violent or threatening ($p < .001$, OR = 6.28, 95% CI: 3.17-12.46) were significantly more likely to be coercively referred to emergency services. Other results showed that those who were older (*p* < .001, OR = 1.15, 95% CI: 1.06-1.24), Black (*p* = .028, OR = 2.72, 95% CI: 1.11-6.63) and perceived as violent or threatening (*p* < .001, OR = 5.01, 95% CI: 2.34-10.74) were more likely to receive any coercive intervention when comparing the Black patient group to a non-Black patient reference group (see Table 10). Logistic regression analyses also showed that being older (*p* = .001, OR = 1.14, 95% CI: 1.05-1.23), Black (*p* = .016, OR = 3.01, 95% CI: 1.23-7.35) and perceived as violent or threatening (*p* < .001, OR = 5.73, 95% CI: 2.67-12.29) predicted higher likelihood of legal coercive intervention when comparing all patient groups (See Table 9).

Patient Interviews

To uncover qualitative reasons for quantitative findings, such as the experience of coercion in Black FEP patients and what these experiences may mean for Black identity, help-seeking, and community life, semi-structured qualitative interviews were conducted to interpret discrepancies and explore how differential treatment may influence attitudes to care among Black FEP patients. A total of five Black, English speaking, male FEP patients, who experienced either medical or legal coercive interventions, were recruited. All participants were male and single, between the ages of 19 and 38 years, all but one participant were unemployed, and most had some university or college education (*n* = 3). Participants were selected from an archived FEPP dataset and interviews were conducted to explore Black FEP patients' experiences in clinical settings and how they make sense of coercive events. Several themes emerged from patient interviews (see Figure 2). These themes illustrated how coercive treatment influenced patient help-seeking behaviours and attitudes towards mental health services.

Four Core Experiential Themes

For the present study, themes that were present in all (5/5) or majority (4/5) of participant interviews were labelled “core themes.” Similarly, themes that were present in some but not all (3/5 or 2/5) of the narratives but nonetheless were relevant to the study objectives, were labelled as “peripheral themes.” Four core experiential themes emerged from the data: *sense of confusion, forced medication, feelings of loneliness,* and *police contact* (see Table 12).

Sense of Confusion. The first core experiential theme to emerge from qualitative data analyses was a sense of confusion. All participants mentioned how they did not understand what was going on and wished for someone to have explained things to them once they were referred to the hospital or before undergoing coercive measures. Participant 4 states, “It was very confusing because I didn’t know what that [medication] means. Even now, I don’t know what it means.” A sense of confusion emerged for a variety of reasons. Participant 1 felt it was due to his lack of education but also psychoeducation to interpret the diagnosis: “You drop out of school and end up in the hospital that’s the double wammy, you know? Cause you’re uneducated, and you’re sick, sick to the knowledge that you don’t understand.” Participant 3 expressed a sense of confusion because of the contradictory statements made by the court and psychiatrist: “The thing is they said I’m not guilty, but I still did the time. How am I not guilty, but I still did the time? If I’m not guilty, I’m supposed to leave the hospital as soon as I get not guilty.” Similarly, Participant 4 felt confused due to the lack of communication between medical and legal authorities during the referral process: “I spent many time travelling from place to place and I didn’t know very well what was happening, and what was going to happen.”

Other participants did not understand their illness or the clinical events they underwent due to cultural differences in the explanation of illness and lack of familiarity with mental health services as a newcomer to Canada. Participant 5 stated he was confused about his diagnosis for a while, "It wasn't until like long time after that, that I understood that there was a problem in the way I was thinking." Participant 2 explained he was in denial about his diagnosis in the emergency room because he felt it was something more spiritual. Participant 2 thought his father was practicing the main Congo religion (*Spirit of Nature*) which he didn't know about and transferred it onto him. His cousin experienced a psychotic episode one week after him, so he was not sure if it was medical or "wished." Although Participant 2 self-identified as Christian, he observed the main religion of the Congo. For these reasons, he did not find the antipsychotic treatment helpful and saw it as a "placebo" as did his African friends who were in Canada. Similarly, Participant 1 expressed additional confusion due to cultural differences in service provision: "Some Black people haven't gone to the hospital since they were in my country, then they travel here and it's the first time they're in the hospital, so it's a new form of adaptation, you know?"

Forced Medication. The second experiential theme to emerge from patient interviews was the concept of forced medication and treatment. Participants expressed initial negative attitudes toward IM injections and oral antipsychotic medications. Some participants feared medication due to the belief it would change some aspect of their identity: "My fears were like it would alter the way I was thinking. It would interfere with the natural, my natural state of mind" (Participant 5). Whereas, others felt it would make them more ill: "I keep thinking that if you take too much of the meds, maybe you can get the sickness even more" (Participant 1).

Similarly, Participant 3 felt he had no say or control over his body: “She put me away and made me take pills out of nowhere. I never used to take pills.” Participant 4 expressed that the lack of communication contributed to the initial reluctance: “It was like very confusing because at first the doctor tried to give me some medication that at first I wasn’t really into take it. So we had to go in front of the judge to take an ordinance. A prescription for treatment.” He further added, “They just told me here is the medication, you have to take it. But no one really explained it to me how it was going to affect me” (Participant 4). However, some participants over time grew comfortable with medication once it reduced their symptoms. Participant 2 expressed that he was okay with monthly IM injections but did not like the side effects of weight gain. Participant 4 stated it reduced his symptoms despite his initial confusion: “In the beginning, I didn’t know what it was, what it was going to do to me. Right now, I think it’s helpful because I don’t have that type of disconnection anymore.”

Feelings of Loneliness. The third core experiential theme derived from the data was feelings of loneliness. Many participants felt they were alone due to the lack of social support among family members or due to their illness making their mind “different” from others. A majority of the participants had an absent father figure, and this explicitly affected Participant 2, who explained that he experienced auditory hallucinations because he wanted to hear his father’s voice. Participant 2 expressed feelings of loneliness after his father’s passing and that it was hard on him. Similarly, Participant 3 mentioned the loss of his father, “After two months I did in the hospital, my dad was gone after two months.” Participant 3 expressed further feelings of isolation when he discussed moments he felt alone at school: “When I meet new people, I just don’t know how to make friends”, and at court, “I had nobody in court. My parents weren’t in court. It was only me.”

Feelings of loneliness also emerged when participants discussed their experience of being diagnosed with psychosis or schizophrenia. Participant 4 explained that he felt alone in his illness because he could not talk to others about it: “I don’t understand, me, *myself*. I don’t understand it at the level that I feel like I could talk to someone about it.” Similarly, Participant 1 expressed the experience of stigma from family members:

> I feel kind of like the stigma on me because I don’t want to tell too much of my family member because the closer you are to your family especially Caribbean family, and they don’t know the situation, they will not have you, not console you, but they will just laugh sometimes…I would feel shy, and go more in the box and so that’s the reason why I didn’t want to tell them. (Participant 1)

On the other hand, Participant 5 felt his friends and family were supportive, but still felt alone in that his mind was “different.” He explains, “I feel like I’m different as my doctor put it…I have different moods than my surroundings, my friends or my family or something. I know there’s something different, but I just try to not to think about it too much” (Participant 5).

Police Contact. The fourth experiential theme elicited from patient interviews was police contact. 4 out of 5 participants had a unique experience with 911 contact leading to a coercive referral to the hospital via police, ambulance or court-order. Participant 4 experienced being hit with a police car and tasered while in a psychotic episode: “The police told me to drop the knife, but I didn’t realize what was happening. The situation escalated very quickly, and I end up walking and the police just hit me with the car, and I dropped the knife at that moment, and they handcuffed me." Upon arrival to the hospital, he was sent to a detention centre to receive a court-order: "The people in the detention transferred in a big truck…we were transferred in that truck from the detention center to the justice court or Palais de Justice" (Participant 4). Participant 3 was also brought by police officers after being referred by his high school. Participant 3 exclaims:

> The school was trying to suspend me so I just okay, forget my suspension, so I just left the office, cause if I like stayed, I would've got arrested anyways. But I felt like something was going to happen, I felt like they were going to call the police on me. It's like I know why white people like to call the police so much. So, I just left and got home, and when I reached home my door started getting knocked down and when I looked, I saw the police. (Participant 3)

Participant 2 and 5 recalled being brought to the hospital via ambulance. Participant 2 explained that he was standing in front of the National Defense, which is a police station in Paris, when he experienced an episode and was brought to the hospital. Whereas, Participant 5 explained that he was at home: "I was at work and on lunch time I just went back home because I couldn't stand it and from there I went to the ambulance. My father was there and I wasn't acting normal so he called an ambulance."

Four Peripheral Experiential Themes

Four additional themes that emerged in a smaller proportion of the sample were: *discrimination and prejudice, feeling unheard, mistrust,* and *feeling powerless* (see Table 12).

Discrimination and Prejudice. The first peripheral theme derived from data analyses was discrimination and prejudice. Some FEP patients related their experience in the hospital to the experience of African American men in jail. Participant 3 states, “I really find nothing was wrong. I feel like they were just trying to send me to the jail. If I was in the States, they’d probably send me to a jail for no reason. You know how they say school brings you to jail sometimes? If I was in the States, they’d send me to jail but I guess here, they send me to a hospital because they have nothing on me.” Participant 3 expressed throughout his interview that he felt the hospital was a “lock-up” and that his end-point was jail: “I still feel like a jail cell. I don’t know how to explain it. It’s a hospital. If I keep switching from hospital, to hospital, to hospital, then eventually I will switch to a jail cell.”

Participant 1 also echoes this sentiment when discussing his experiences growing up as a Black man: “I’ll think it’s because I’m black but it’s not that, you know? It’s just me. It’s just me, how I grew up blackish with American state of mind, think everyone is out to get me sometimes.” He further explains his experience growing up and how stigma from others leads him to feel judged: “Not for myself, but from others. If it takes a community to grow a child, it feels like that community had the power already to judge the child before it is even born, you know?” (Participant 1). This stigma was also expressed by Participant 3 in which he stressed during his interview that he was not being violent, as often assumed of Black men (Dukes & Gaither, 2017), and that he was simply listening to music minutes before he was referred to the hospital:

> I didn’t even start a fight in the school. I was in no fight, I was in no argument with no teachers, I wasn’t doing none of that. I just hit the table one time, and everybody was

> talking. The teacher wasn't even in class. The teacher gave us something to do, but I finished it. And I was listening to my music and I hit the table once. (Participant 3)

Experiences with discrimination and prejudice not only emerged from interactions with authorities, but also through interactions with family and friends. Participant 5 explained the challenges he faced as a bi-racial child in Montreal and feeling excluded because of it. He states:

> I'm not black, I'm not white, I'm in between the two so I was, and I didn't really know what to say or what to do so I was, I didn't ask myself questions but I don't have so much problem, like it's hard for me to find the right type of friends because some friends will, well some people won't include me in the group so much because I'm always different. There's not a lot of biracial people in Montreal. (Participant 5)

Feeling Unheard. The second peripheral theme that emerged from the data was the wish to be heard. Participants expressed how they felt ignored by mental health professionals and their mental health needs were unmet. Participant 1 explains, "Most of the time you don't get back the feedback that you, that will…I don't know, motivate you? You just get back a blank answer or points off, bounce off of you or questions off of, you know? And you don't get to be heard all the time. It's mostly by schedule if you don't finish telling all of the story within the half an hour someone else comes in and tells their story, you know?" He further elaborates that he finds it hard to express himself and wishes to be represented:

> I never had a lawyer, it's just that I always felt like I should be represented because most of the time I bite my tongue…Most of the time I'm biting my tongue I'm like a deer

> caught in the headlines. Just there wanting to express myself, ‘can someone just speak for me in my head’? (Participant 1)

Participant 1 also expressed the need for a Black mental health professional to feel fully understood, “I was thinking I should be sent back home when my sickness arose, when I had my first episode. I always think I should do that, that I should have a black doctor or nurse, someone who connects with me from the island and checks and explain.” Similar, Participant 4 expressed the need for someone to address his needs and listens to his medication inquiries prior to treatment: “Maybe if they explain to me what was going on and what was going to happen because at the beginning when the doctor just said me, here is the medication they didn’t explain to me why I have to take the medication.”

Mistrust. The third peripheral theme elicited from the transcripts was mistrust, specifically toward mental health professionals. Some FEP patients reported a sense of mistrust due to their mandated psychiatric care: “I don’t know, at the core of everything, I really don’t trust being in the hospital. Because of the forced treatment, and all these things, being poked with needles and still going on, it just feels like an invasion sometimes” (Participant 1). Participant 1 shared that he initially opened up and explained himself to the ER physician, but felt the physician betrayed him by forcing him to stay in the hospital: “It depended on that explanation. I didn’t know that. I just thought I had to explain myself to the doctor and that was the deciding doctor that would seal my fate, you know? I didn’t know that.” Additionally, when Participant 1 was diagnosed, he felt that the providers were trying to control him: “They say I’m schizoaffective and I’m not too sure what that means…I’m kind of like ‘woah, woah, stay back, this is my mind’, you know?”

Even when the clinical team was supportive at times, he still felt the need to "police his mind" and it was an invasion because trust was not established: "I'm here sick and so much people are taking care of me but none of my family, and it's not a family member you're sitting down to and talking to, so anytime you're feeling stuff about the family, just it feels like an invasion" (Participant 1). Participant 3 also expressed feelings of mistrust not only toward mental health providers, but even toward his family: "That's my mom, that's the police. That's why I don't trust her too much. To me she's the police."

Powerless. The last peripheral theme that emerged from the qualitative data was feeling powerless. As FEP patients have experienced coercive measures whether medically or legally, they reported a sense of helplessness from their psychiatric treatment. Participant 3 reported feeling stuck and unable to escape given his treatment at the FEPP is under the jurisdiction of the court: "I cannot escape it. I cannot escape the government…I don't have a choice. The only thing I can do is just survive though." Similarly, Participant 1 reported feelings of powerlessness as a sick patient, "I feel like I'm weak because I'm in the hospital and it beats your judgement sometimes," but also as a man by not managing the household, "I was partly responsible for it because I was the man of the house and nothing was going good."

Help-seeking Behaviours

Attitudes toward mental health services and its influence on help-seeking behaviours varied among the 5 participants. When asked if participants would be open to additional mental health services or seeking support, a variety of responses emerged.

Participant 1, who experienced 7 years of psychiatric treatment, stated, “I don’t think it will change too much. I feel like it could, but I would just be putting myself out there for some crazy stuff.” Participant 1 expressed how he had no social support and it was hard to come to appointments: “It feels like I have no one there to come with me to the appointments and it just feels like I’m alone.” Furthermore, feeling unheard and unseen in medical settings contributed to somber attitudes toward treatment: “Well coming from my standpoint that I’m black, and it’s like I wanted to be heard more a little bit” (Participant 1). Similarly, Participant 3, who was referred to FEPP 2 years ago, responded: “No, it’s scary. If I came here some other time bro, I wouldn’t. If they keep me here for another time, they better have some weed for me because I wouldn’t even stay.” When Participant 3 was asked for a rationale, he further explained that he disliked the police contact: “There’s nothing that can change it unless they stop. The police stop harassing me and stop coming and picking me up and just dropping me to the hospital that would be good.”

Whereas, Participant 2, 4 and 5 were more open to mental health services. Participant 2, who was diagnosed with schizophrenia 3 years ago, expressed initial hesitancy due to his initial negative experience with medication side effects. However, Participant 2 felt cared for by the FEPP team and found the doctors helpful. Participant 4, who was recently referred in the last year, simply stated he was open to mental health services. In the beginning, Participant 4 mentioned that he did not understand what was going on leading to great confusion, but after the medication reduced his symptoms, he started feeling better, so he became more open to other services available. Likewise, Participant 5 responded, “Yes, I’d be willing to see what services and if it works better than what I have so far, it would be good.” Like Participant 2 and 4, Participant 5 felt confused at first but later grew comfortable with FEPP services after the medication improved his condition and the FEPP team addressed his concerns.

From the experiential themes, it seemed that *loneliness* (lack of social support), *feeling unheard*, *police contact* and *medication* influenced patients' help-seeking behaviours (see Figure 2). Participant 1 and 3 were less open to mental health services due to the lack of social support, feeling unheard and unseen in clinical settings, and the initial contact to the emergency services via police referral. In contrast, participants 2, 4 and 5 were more open to mental health services after the medication reduced their psychotic symptoms, despite their initial reluctance to comply.

The difference between participants and their attitudes toward treatment may involve social support and education. Both Participants 1 and 3 had little to no social support through the course of treatment. Participant 1, prior to his hospitalization, was homeless and had no relatives in Montreal. Similarly, Participant 3 enrolled in a new school with no friends, no girlfriend and had no relatives in Canada from back home. In contrast, Participants 2, 4 and 5 had more social support, potentially making it easier to endure their hospitalization or court-ordered treatment. Participant 2 had a supportive mother and sister. Participant 4 had two supportive older brothers and Participant 5 had supportive parents. For these reasons, Participant 1 and 3 may find participating in mental health services difficult because they know no one, whereas Participants 2, 4 and 5 may find it more inviting and supportive because they can participate with their family members in some of the seminars and sessions.

The other difference between the patients is education. Participants 1 and 3 dropped out of high school, whereas Participants 2, 4 and 5 were well-educated and enrolled in university or college studies. It is possible that the lack of education contributed to further confusion for Participants 1 and 3 making it harder to conceptualize their illness and pursue treatment, but Participants 2, 4 and 5 who pursued higher education may be more insightful about their diagnosis, which may improve attitudes to treatment and services.

Discussion

The purpose of this mixed-methods research design was to employ quantitative and qualitative methodologies to explore the topic of coercion in a sample of FEP patients. Specifically, the research objectives were: (1) to determine whether Black FEP patients are at a higher risk of coercive referral and coercive intervention than non-Black FEP patients; (2) to examine the experiences of Black FEP patients who underwent coercive interventions; and (3) to explore how these experiences may have influenced help-seeking behaviours. Patient chart reviews were analyzed using chi-square tests and logistic regression analyses; semi-structured patient interviews were analyzed using interpretative phenomenological analysis. As well, the study explored the coercive experiences lived by Black FEP patients in the Canadian context and over the course of their treatment. It was expected that Black FEP patients would be more likely to be coercively referred to psychiatric services than non-Black FEP patients, and that there would be a variety of participant responses to interview questions.

Findings revealed that Black FEP patients experienced more coercive referrals via police, ambulance and court order than other patient groups. Previous literature in Canada has also shown that Black patients experience greater police contact and police referral to emergency services (Anderson et al., 2014; Jarvis et al., 2005). In an Ontario study conducted by Anderson and colleagues (2015b), the authors reported that FEP patients of African and Caribbean origin experienced more aversive pathways to care via police or ambulance referral than their Euro-Canadian counterparts. These findings suggest that racial bias may be at play given pervasive negative stereotypes of African American men being violent (Maynard, 2017), and the frequent encounters members of the Black community have with the police (Taylor, 2016). More information is needed to determine how authority figures assess danger , especially in Black men with FEP, and how bias may manifest in institutional settings to produce disproportionate numbers of coercive referrals in this group.

Other important findings were that Black FEP patients were at higher risk of coercive intervention, particularly legal coercion with court involvement, while white and non-Black visible minority FEP patients were less likely to experience coercive interventions overall. The significance of legal coercion, and not medical coercion, among Black FEP patents suggests that there might be racial bias within the judicial system, especially when it is brought to bear on mental health issues in young Black men. In a study conducted by Rachlinksi and colleagues (2008), findings showed that judges harboured implicit racial bias and these biases influenced judgements in court trials. Results showed that white judges had a strong white preference and conformed to racial stereotypes of white is good and black is bad. Findings also revealed from judicial decision making that Black defendants received worse outcomes than white defendants. Due to the interaction between mental health and the law, Black people might be more heavily policed and sentenced in these legal settings (Clemons, 2014). Given the fact that mental health legislation is based on the criterion of “danger” and Black people, particularly Black men, are often deemed to be dangerous (Gordon, 2015), more coercive measures might be rendered by the court to manage perceived risks to the public (Large et al., 2008; Vinkers et al., 2010). Additionally, Black men statistically experience more death my homicide than death by suicide contributing to the stereotype that they represent a danger to others (Griffith & Bell, 1989; Riddell et al., 2018).

Another reason for these findings may be that Black people are perceived to be more helpless and incompetent such that practitioners may not find them sufficiently organized to manage their medications or the mental health system. This is mentioned in the literature in which Black people have historically been perceived as cognitively immature and less capable than members of other ethnic groups (Maynard, 2017). These enduring narratives are still present today and contribute to negative racial stereotypes that Black men are incompetent and need coercive intervention to make sure that they get the care that they need (Nasir et al., 2017).

To further understand the impact of coercive referral and intervention on Black FEP patients, semi structured interviews were conducted. From the qualitative interviews, four core themes and four peripheral themes emerged. The first core theme was a *sense of confusion*. Participants described how inadequate communication by health care providers, different explanatory models of illness, and poor understanding of mental health services as newcomers to Canada all contributed to a sense of confusion. Research has shown that poor communication, cultural insensitivity, lack of trust and use of coercion were barriers to therapeutic relationships and led to poor patient attitudes to care (Gilburt et al., 2008). In a qualitative study conducted by Bropy and colleagues (2016), researchers conducted focus groups with mental health patients to discuss their experience with seclusion and restraints. Results showed that attitudinal barriers involving lack of communication between clinician and patients, paternalistic attitudes from providers, and lack of empathy contributed to patients' negative perceptions of care. These findings suggest the need for improved medical communication in clinical encounters between practitioners and patients. Findings also suggest the need for culturally sensitive interventions for patients with potentially different cultural concepts of illness, and psychoeducation for the family members of the Black patients diagnosed with psychosis.

The second core theme that emerged from qualitative interviews was *feelings of loneliness*. All participants expressed feeling alone due to the lack of social support from relatives or due to their diagnosis making them feel "different" and isolated from others. These findings are also reported in the literature in which there is a positive statistical association between loneliness and psychosis (Michalska da Rocha et al, 2018). In a systematic review, Lim and colleagues (2018) found that feelings of loneliness were common among psychosis patients and often related to psychosocial factors such as lack of family involvement and stigma. Some of the participants also mentioned having an absent father figure. This is consistent with the literature in which Black men are often raised in homes without fathers (Cartwright & Henriksen, 2012), resulting in feelings of loneliness and abandonment (Earl & Lohnmann, 1978; Wilson et al., 2016). These findings suggest that strong social networks are important, and interventions to increase family involvement would prevent treatment discontinuation and reduce feelings of loneliness in patients with psychosis (Taylor et al., 2017).

The third core theme was *forced medication*. All the participants expressed initial fears and negative attitudes toward their prescribed medications. Some participants feared the side effects of their oral antipsychotic pills and some felt the injections were too invasive, whereas others felt that the clinicians did not provide enough explanation regarding how the medication would work or why it needed to be taken. These findings are consistent with the current literature (Demjaha et al., 2017). Hickling and colleagues (2018) found that patients who adhered to antipsychotic medications were more likely to be satisfied with the medical information provided by practitioners. Nikolitch and colleagues (2018) reported that Black FEP patients had poorer adherence to follow-up compared to other patient groups but it was unclear whether this was due to problems with medical communication or a combination of factors. Some authors have attributed the natural unwillingness of Black patients to take medication to medical mistrust and past experimentation on African Americans (Chaitoff et al., 2014; Jarvis, 2012). These findings suggest the need for physicians to be aware of the historical and cultural factors that impact the Black community and that may undermine medication adherence. In addition, these findings highlight the need for clinicians to be more transparent with patients and provide better information about antipsychotics to facilitate recovery.

The last core experiential theme that was elicited from the data was *police contact*. As shown in the literature, Black patients are more likely to be referred to emergency services by the police than are patients from other ethnic groups (Archie et al., 2010; Anderson et al., 2014), and this was evident in the present study as well. All participants reported their experience with police in which some were handcuffed, tasered, hit with a police car or brought via ambulance after 911 was contacted. However, these are not isolated events. Earlier this year, in April 2020, a 26-year-old Black man diagnosed with schizophrenia was shot to death in Brampton, Ontario after he called 911 for help (Nasser, 2020). Similarly, in Montreal, Quebec, a 58-year-old Black man with a history of mental illness was shot outside his apartment after police arrived (Shingler, 2019). These tragic examples, among others, suggest that there may be enduring stereotypes or racial bias in which Black people, particularly Black men, are deemed more dangerous than members of other ethnic groups (Mears et al., 2019; Metzl, 2010; Oliver & Fonsah, 2002). Those who are diagnosed with severe mental illness are often seen as a public threat (Corrigan & Watson, 2005); thus, the intersection of race and mental illness place Black FEP patients at greater risk for coercive measures. Training in basic mental health principles is needed for police officers to learn how to better handle patients during a psychotic episode. As well, officials must assess their own potential bias to prevent further stereotyping of racial minorities, and research must make a contribution to learn how racial stereotypes have informed public opinion.

In addition to the core experiential themes, four additional peripheral themes emerged from data analyses. The first peripheral theme was *discrimination and prejudice*. After conducting patient interviews, it was evident among a few participants that contemporary issues plaguing the Black community in institutional settings, such as racial profiling (Closs & McKenna, 2006), over-representation in jails (Reasons et al., 2016), and police brutality (Taylor, 2016), seemed to have influenced the attitudes of young Black FEP patients. Some participants expressed how they expected to be sent to jail and that the hospital was a form of unlawful confinement. Participants also mentioned the prejudice they experienced growing up as a Black person and how they constantly felt judged, excluded and targeted by others. These feelings expressed by participants are also mentioned in the literature, in which Black men report feeling targeted not only by police (Taylor, 2016), but in schools (Ellis et al., 2018; Nasir et al., 2017), in the media (Dukes & Gaither, 2017), in sports (Comeaux, 2018) and in work (Bell, 2017). These sentiments were anticipated by Franz Fanon (1952) who wrote: “The Negro enslaved by his inferiority, the white man enslaved by his superiority alike behave in accordance with a neurotic orientation” (p. 60). These findings suggest that negative racial stereotypes and discrimination contribute to feelings of inferiority and suspicion among members of the Black community due to collective, historical and widespread denigration of Black people (Boyd & Mitchell, 2018; Maynard, 2017; Mensah, 2002; Metzl, 2010). Thus, mental health professionals must be sensitized to these matters and future research urgently needs to explore the impact of racial discrimination on the mental health status of Black people and other ethnic minorities.

The second peripheral theme that emerged from patient interviews was *feeling unheard*. This theme is commonly reported in literature among Black patients, who often express unmet mental health needs and the feeling of being ignored, unheard and unseen in healthcare settings (Brown, 2016; Woodgate et al., 2017). In this study, Black patients wished to be heard and felt dismissed when their medical concerns were not addressed. One participant even expressed the need to be legally represented in order to have his voice fully heard. As well, he also requested the presence of a Black mental health professional as he felt they would be more attentive. The preference for racial concordance was also shown in a study conducted by Chaitoff and colleagues (2014) who found that Black participants preferred health institutions with diverse staff, but particularly Black healthcare workers. These findings suggest that it is important for mental health professionals to recognize the challenges ethnic minorities experience in clinical settings and to actively promote patient welfare, and patient engagement, in all medical matters. Findings show that lack of attentiveness by clinicians contributes to treatment disparities and that improving provider-patient interactions will improve the clinical experience for Black patients.

The third peripheral experiential theme was *mistrust*. A few participants expressed mistrust toward mental health professionals as a result of practitioners dismissing their concerns, their initial referral to the hospital via police contact, and being forced to take medication they initially refused. These negative attitudes toward medication have also been shown in the literature about Black patients, which have reported that they are reluctant to participate in health care services due to the belief that experiments like those at Tuskegee could happen again, that misdiagnosis and clinician bias will prevail in clinical interactions, and misgivings due to cultural mistrust (Chaitoff et al., 2014; Hankerson et al., 2015). This historical and cultural mistrust is further perpetuated by contemporary issues in which black patients are over diagnosed with psychosis (Schwartz & Blankenship, 2014), involuntarily admitted (Oduola et al., 2019) and referred to psychiatric services via police (Anderson et al., 2015b; Bhui et al., 2015). These findings suggest that mental health professionals must work to address these disparities in mental health frameworks and unweave the mistrust that has developed over centuries, to make amends and establish rapport with the Black community.

The fourth and last peripheral theme was *feeling powerless*. Some participants expressed a sense of powerlessness as a result of their coercive experiences or due to being unable to fulfill personal obligations because they were sick in the hospital. One participant felt like a failure for not upholding the household as a man should; another participant felt helpless due to his court-ordered treatment. These feelings of powerlessness are also mentioned in the medical literature about the dynamics of clinical interactions. In a qualitative study conducted by Verbeke and colleagues (2019), results showed that power played a significant role in the therapeutic relationship between psychiatrists and patients. When practitioners exercised their power, patients felt that that they were one-sidedly approached as a sick patient and their subjective lifeworld was neglected. These findings suggest the need to promote patient autonomy in clinical settings to enhance the therapeutic alliance and improve attitudes toward psychiatric care.

Qualitative data was also collected to determine the influence of coercion, when it occurred, on help-seeking behaviours. Of the eight identified experiential themes, four played a greater role in influencing patients' attitudes to care and help-seeking behaviours. The four experiential themes were: social support (*loneliness*), *feeling unheard, police contact* and *forced medication* influenced patients' help-seeking behaviours. Feelings of loneliness, due to the lack of social support, made patients feel alone in clinical settings as they had no one to rely on outside mental health professionals to support their treatment engagement. Feeling unheard and unseen by providers led patients to feel that their thoughts and opinions did not matter, thereby reducing incentives for patients to participate in clinical decisions. Similarly, police contact in the context of psychosis led to negative attitudes toward care, and affected most of these young participants from their first encounter with psychiatric services, which often involved police and/or ambulance. Similarly, court-ordered medication worsened some patient attitudes because they had to conform to the treatment regime despite experiencing side effects; but for some the medication improved attitudes as it reduced psychotic symptoms, making patients feel better and more open to treatment and services. These findings are consistent with previous literature. In a

Canadian study, Ferrari and colleagues (2015) found that patient awareness of symptoms and general knowledge of mental health services greatly influenced help-seeking behaviours among African and Caribbean origin groups with psychosis. These findings suggest an urgent need to improve the experiences of Black FEP patients who are encountering mental health services for the first time. In a systematic review conducted by MacDonald and colleagues (2018), results showed that pathways to care for young people were complex and standardization is needed to reduce confusion and improve the experience for youth, especially at initial contact with services. Based on these themes, it will be important to encourage family involvement, re-examine police involvement in mental health calls, and for practitioners to be culturally sensitive to Black patients' mental health needs. This may help to facilitate patient engagement and openness to mental health services.

Regarding the differences between participants and help-seeking behaviours, findings revealed that social support and education might play a significant role. Previous studies show that social support from extended family is important in Black families (Dressler, 1985; Taylor et al., 2017). As well, Hammer and colleagues (2013) found that highly educated men were more open to mental health services than men with a high school degree or less. These results suggest the critical importance of social and family networks to facilitate the treatment of patients, as well psychoeducation to help patients understand their diagnosis and the implications of treatments such as medication.

Implications

Research Implications

The results of this study redress a gap in the clinical and research literature on the effects of coercive experiences of Black patients in medical settings and the effects of these experiences on the psychiatric treatment of psychosis. This study also sheds insight on the influence of coercive interventions on attitudes to help-seeking behaviours and to mental health services. To date, there is limited data on the experiences of involuntarily admitted patients, specifically among the Black FEP population in Canada. This study provides preliminary data on these issues.

Studies have shown that there is under-representation of racial and ethnic minorities in clinical research (Waheed et al., 2015). Heinrich and colleagues (2010) reported that most of the studies published in top tier scientific journals were composed of WEIRD (Western, Educated, Industrialized, Rich and Democratic) samples. Thus, the current study extends the existent literature by contributing to the dearth of research on Black Canadians. Overall, there is little discussion on racism in Canada (Mensah, 2002). Canadian provinces and territories do not collect race-based data in order to avoid labelling people, despite collective wishes to do so (Mulligan et al., 2020) and despite the fact that collecting race-based data in diverse countries such as Canada and the US is complex and mixed (Kaneshiro et al., 2011; Varcoe et al., 2009). This article calls for the collection of race-based data because failing to gather this information can cause further harm to racial and ethnic minorities by neglecting their specific health issues (Strmic-Pawl et al., 2018). Avoiding the use of racial language to prevent labelling people, also known as *new racism* (Barker, 1981), contributes to colorblindness and makes the conversation surrounding racism more complicated. Therefore, in this study, ethnic statistics were counted and racial data were collected in order to address potential differences between patient groups in Canada. Results from this study contributes to the clinical literature, especially in the Canadian context, and highlights the importance of research on health care disparities to address the challenges lived by members of ethnic minorities.

Clinical implications

The results of this study can be used to improve clinical interventions and triage procedures so that patients may participate more fully in treatment decisions. Racial stereotypes can influence patient symptomology and potentially lead to more coercive measures. Since the Mental Health Act passed by government officials in 1983, Black male patients under the age of 30 were often perceived by clinicians to be more threatening, incoherent and disturbed leading to coercion (Pipe et al., 1991). This article calls for the assessment of potential racial stereotyping among practitioners in medical institutions and how clinician bias may contribute to treatment disparities in Black patients. Although the findings suggest that the issue may lie more with legal and penal services, it is still important for members of the medical community to be aware of their own biases to further improve treatment alliance and service provision (Santiago & Miranda, 2014). Within the mental health system, practitioners are expected and encouraged to exercise their power to maintain public safety despite patient wishes. Thus, the study authors encourage clinicians to carefully assess how they make these judgements and exercise caution to prevent harm to the patient. There is a need to promote patient participation in treatment decisions and maximize patient autonomy in clinical care. More medical education and training is needed to encourage culturally sensitive care particularly among Black patients with a long history of inferior care in psychiatry (Jarvis, 2012; Metzl, 2010). Clinicians need to be aware of the historical and contemporary issues regarding members of the Black community in mental health care to build medical trust and establish rapport. A cultural context can promote engagement with the Black community and also reduce the use of coercive measures based on racial bias or stereotypes. This article also calls for mental health professionals to increase family involvement among Black patients to facilitate recovery.

Policy Implications

This study can also inform policymakers on how to promote patient welfare and autonomy in organizational contexts. Coercion is enforced under the Mental Health Act if the court finds the patient a danger to themselves or others (Barnett et al., 2019). The dangerousness criterion in mental health legislation must be critically reviewed by policymakers. Studies show that the criterion of danger can contribute to longer duration of untreated psychosis, and increase risk of suicide and violence in FEP patients (Large et al., 2008). Researchers argue that danger is a problematic criterion for coercion and lacks scientific support leading to ethical, professional and judicial issues (Verbrugghe & Vandenberge, 2008). In addition, forced court-ordered treatments temporarily suspend the rights of the individual and undermine patient autonomy in medical institutions. Policy makers must carefully assess the justification for coercion in balance with patient welfare and examine whether racial bias may be present in court proceedings. This article calls for the need of institutional and structural cultures and norms to be addressed, especially within the medico-legal system in which Black patients are disproportionately detained by the court compared to other ethnic groups. At forensic psychiatric hospitals, such as Phillipe Pinel in Montreal where patients are frequently detained for periods of observation, further study is needed to determine how decisions are made and whether implicit racial stereotypes are at play leading to excess coercive measures in Black people.

As laws and policies are rewritten to provide more equal access to mental health services, the role of ethnocultural status in clinical settings will inform future policies and mental health care programs**.** This article calls for diversity in health care institutions to increase patient trust and for organizational contexts to reflect their commitment to health equity. Given that other institutions, such as the police force, are involved with legal matters, the study also points to the urgent need for improved mental health training for police officers. Police officials need practical guidelines and procedures about how to handle patients during a psychotic episode to de-escalate tensions and prevent additional harm when they are brought to emergency services.

Limitations

Several limitations were identified in this study. For the quantitative sample, a total of 71 participants were removed from data analysis. The majority of these were White FEP patients, which was acceptable because sufficient numbers remained to conduct statistical analyses. Although the study focused on Black Canadians, it is important to note that there are differences between African and Caribbean groups which were lost when these groups were combined. However, the scale of the study did not allow for this level of division in data analyses. The method of assigning ethnicity from medical records is also a limitation, as relying on physician notes may have resulted in misclassification. Additionally,, there was some “not noted” sociodemographic characteristics in patients charts as a result of poor systemic recording from health professionals. For these reasons, migrant status, which is often associated with negative pathways to care (Anderson et al., 2017), was not included in data analyses. Next, all comparative findings among groups were correlational, so causality could not be resolved. Black FEP patients are more likely to be coercively referred to mental health services than other patient groups, but it cannot be concluded that the reason for this discrepancy is because these patients are Black. However, these findings do suggest that ethno-cultural status may play a role in mental health treatment. Similarly, for the qualitative sample, only five Black FEP patients were interviewed for the study. The small sample size was due to the outbreak of COVID-19, which abruptly halted study recruitment midway through the process. The qualitative sample was also limited to the experiences of Black, English-speaking, males in Montreal, who were diagnosed with psychosis. In addition, the experiences of FEP patients were limited to the interview questions. Findings cannot be generalized to all FEP patients in Canada, or even to Black patients with psychosis in other cities. However, despite the limitations, this study extends contributes to the literature on FEP patients and coercion in Canada, which has been limited.

Future directions

Future research could use triangulation to explore the topic of coercion among mental health practitioners, families and patients. Research could carefully evaluate intervention strategies to encourage family involvement in young FEP patients, particularly Black FEP patients, and to assess the influence of family involvement, particularly fathers (who are often absent), on mental health outcomes. Information could also be collected on police attitudes toward police referrals to emergency services to further understand the encounters patients experience prior to coming to the hospital. Given that migrant status and ethnicity are highly related to negative pathways to care (Anderson et al., 2017; Rodrigues et al., 2020), future research should explore the relationship between first generation African and Caribbean groups with psychosis and rates of involuntary admission. Future studies could also investigate cultural differences in coercive treatment and how to provide culturally appropriate care even when patients are involuntarily admitted to the hospital or forced into treatment by the courts. More research should look at the interaction between mental health and law and the implications of policy and procedures on patient welfare. Studies could also explore the mental health status of ethnic minorities in Canada and how they compare to minorities living in Quebec. Since there is little discussion on racism and discrimination in Canada (Mensah, 2002), future studies should explore the role of judicial bias and clinician bias on coercive outcomes for Black patients who are vulnerable to negative racial stereotypes in these institutional settings. Studies have been mixed on whether Black patients are at risk of coercive referral to mental health services (Anderson et al., 2015b; Archie et al., 2010; Jarvis et al., 2005) or not (Rotenberg et al., 2017). Therefore, more Canadian studies should be conducted to clarify this matter.

Patient Recommendations

The patients interviewed for this study made several recommendations. The first was to improve the mental health experience of Black FEP patients by the clinicians taking the time to carefully explain and provide information so patients can clearly understand. The second recommendation was to foster diversity in clinical settings by hiring Black health care providers, which in turn may create good will and increase medical trust with diverse clients. Third, minority patients also require more time for their concerns to be attentively addressed and for practitioners to be receptive to cultural differences in the meaning of illness and healing.

Conclusion

Past studies have shown that there is differential treatment in psychiatric care among the members of different ethno-racial groups. Recent literature has shown that Black patients are disproportionally coercively referred via police to mental health services (Bhui et al., 2015; Oduola et al., 2019). There is limited research on this topic in Canada. This study addressed the gap in the psychiatric and clinical literatures by examining the relationship between ethnicity and coercive intervention in a treated sample of FEP patients and exploring their experiences to learn about their attitudes to care in a Canadian setting. Using a sequential, exploratory, mixed-methods approach, retrospective chart reviews were performed, and qualitative data was collected from patient interviews to address the research objectives. The objectives of the present study were: (1) to determine whether Black first episode psychosis (FEP) patients are at a higher risk for coercive referral and coercive intervention than non-Black FEP patients; (2) to examine the experiences of Black FEP patients who underwent coercive interventions; and (3) to document how these experiences may have influenced help-seeking behaviours. Findings from this study confirmed that Black FEP patients are significantly more likely to be coercively referred and coercively treated than patients from other groups. This study revealed that themes of *loneliness, feeling unheard, police contact,* and *forced medication* impacted Black FEP patients' attitudes toward care and influenced help-seeking behaviours. However, more research is needed to further understand the role of ethnocultural status in mental health care, and what this could mean for members of the Black community.

International studies from the US and UK have shown that Black patients experience disproportionate rates of coercion, police referrals and diagnosis of psychosis (Archie et al., 2010; Bhui et al., 2015; Schwartz & Blankenship, 2014). This suggests that systemic racism may be an international problem embedded in the medical institutional frameworks of nations and health care systems. Racial discrimination and prejudice are an important public health issue and must be addressed in order to ensure the well-being of all. Given that the purpose of medicine is to promote patient health and well-being, it is important to address the unmet mental health needs and health care disparities experienced by all patient groups regardless of class, gender, socioeconomic status and ethno-cultural category. Given the historical trauma and contemporary disparities that Black patients continue to experience, it is the responsibility of psychiatric professionals to dismantle medical mistrust, become aware of the historic and cultural disadvantages of Black patients as they seek psychiatric treatment, and restructure psychiatric services to provide optimal care for all.

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Tables

Table 1. Coercive Intervention Measures

Variable	Measure	Description
Legal	Garde preventive	Preventative confinement form completed by a physician, lasts up to 72 hours
	Garde provisoire	Temporary confinement for psychiatric assessment judgement rendered by the Court of Quebec
	Garde en etablissement	Confinement in an institution judgement rendered by the Court of Quebec, lasts up to 30 days
	Outpatient court ordered treatment	Mandated adherence to outpatient treatment plans by the Court of Quebec, usually lasts for 12 months or longer
	Tribunal administrative du Quebec (TAQ) involvement	Patient is declared unfit to stand trial or is found to be not criminally responsible for a crime and is referred to the Tribunal for periodic follow up to monitor adherence to disposition
	Police contact	Patient is referred to the hospital via police officers
	Immigration detention	Arrested at the border and detained at an immigration holding centre
	Youth protection involvement	Patient is under institutional protection and primary care of the government for some period of time before the age of 18 (Youth Protection or Batshaw)
Medical	Use of seclusion	Placed in an isolated room
	Code white	Show of force
	Physical restraints	4-point restraints placed on arms and legs
	Urgent intramuscular injection (IM)	Medication is injected directly into the patient’s muscle, often given in the emergency room

Table 2. Phases of the IPA process

Phase	Activity	Actions
1	Immersion/Familiarization	Reading and re-reading of interview transcripts to become immersed in the data and draft relevant notes
2	Developing emergent themes	Transforming initial notes into emerging themes
3	Clustering	Clusters of themes are labelled and grouped based on conceptual similarities; major and minor themes are created
4	Forming a summary table of the themes	Major and minor themes are illustrated with select quotations in a table
5	Construction of a narrative account	A write-up is made using the themes and quotations in the final table. Each theme is illustrated with select extracts to provide depth, then followed by analytic comments of the researcher

**as cited in Shine & Bourne (2012)*

Table 3. Overall Sample Characteristics

Variable	*N*	%	M(SD)	Min	Max
Ethno-racial category					
White	96	46.15			
Black	42	20.19			
Non-Black Visible Minorities	70	33.65			
Latinx	4	1.92			
Arab	27	12.98			
Asian	38	18.27			
Mixed	1	0.48			
Age			22.87(4.51)	16	40
0-20	75	36.05			
21-30	122	58.65			
31-40	11	5.30			
Gender					
Male	141	67.79			
Female	67	32.21			
Marital Status					
Single	191	91.83			
Married/ Cohabiting	9	4.33			
Separated/Divorced	7	3.37			
Widowed	1	.48			
Violent/Threatening Behaviour					
Yes	68	32.70			
No	140	67.30			
Substance Abuse					
Yes	85	40.90			
No	123	59.10			

Table 4. Ethnic Differences in Coercive Referral

RACE		Coercive Referral No	Coercive Referral Yes	Total
White/Caucasian	Count	73.00	23.00	96.00
	Expected count	64.15	31.85	96.00
Black	Count	21.00	21.00	42.00
	Expected count	28.07	13.93	42.00
Non-Black Visible Minorities (Latinx, Arab, Asian, Mixed)	Count	45.00	25.00	70.00
	Expected count	46.78	23.22	70.00
Total	Count	139.00	69.00	208.00
	Expected count	139.00	69.00	208.00

Chi-Squared Tests

	Value	df	*p*
X²	9.245	2	.010
N	208		

Table 5. Ethnic Differences in Legal Coercive Intervention

RACE		Legal Coercive Intervention No	Legal Coercive Intervention Yes	Total
White/Caucasian	Count	44.00	52.00	96.00
	Expected count	39.69	56.31	96.00
Black	Count	8.00	34.00	42.00
	Expected count	17.37	24.63	42.00
Non-Black Visible Minorities (Latinx, Arab, Asian, Mixed)	Count	34.00	36.00	70.00
	Expected count	28.94	41.06	70.00
Total	Count	86.00	122.00	208.00
	Expected count	86.00	122.00	208.00

Chi-Squared Tests

	Value	df	p
X²	10.92	2	.004
N	208		

Table 6. Ethnic Differences in Medical Coercive Intervention

RACE		Medical Coercive Intervention No	Medical Coercive Intervention Yes	Total
White/Caucasian	Count	73.00	23.00	96.00
	Expected count	69.23	26.77	96.00
Black	Count	26.00	16.00	42.00
	Expected count	30.29	11.71	42.00
Non-Black Visible Minorities (Latinx, Arab, Asian, Mixed)	Count	51.00	19.00	70.00
	Expected count	50.48	19.52	70.00
Total	Count	150.00	58.00	208.00
	Expected count	150.00	58.00	208.00

Chi-Squared Tests

	Value	df	p
X^2	2.933	2	.231
N	208		

Table 7. Ethnic Differences in any Coercive Interventions including Medical and Legal

RACE		Any Coercive Intervention No	Any Coercive Intervention Yes	Total
White/Caucasian	Count	42.00	54.00	96.00
	Expected count	37.85	58.15	96.00
Black	Count	8.00	34.00	42.00
	Expected count	16.56	25.44	42.00
Non-Black Visible Minorities (Latinx, Arab, Asian, Mixed)	Count	32.00	38.00	70.00
	Expected count	27.60	42.40	70.00
Total	Count	82.00	126.00	208.00
	Expected count	82.00	126.00	208.00

Chi-Squared Tests

	Value	df	p
X^2	9.214	2	.010
N	208		

Table 8. Predictors of Coercive Referral (*N* =208)

	Estimate	SE	OR	*z*	95% CI LL	 UL	*p*-value
(Intercept)	-3.56	0.92	0.03	-3.86	0.01	0.17	< .001
Age	0.08	0.04	1.09	2.24	1.01	1.17	.025
Black	0.56	0.40	1.75	1.42	0.81	3.80	.156
Gender (Female)	-0.09	0.38	0.91	-0.24	0.43	1.92	.809
Violent/ Threatening Behaviour	1.84	0.34	6.28	5.26	3.17	12.46	< .001
Substance Abuse	0.29	0.35	1.33	0.83	0.68	2.63	.408

Model $X^2 = 41.77$, *df* = 4, *p* < .001

Table 9. Predictors of Legal Coercive Intervention (*N* =208)

	Estimate	SE	OR	*z*	95% CI LL	 UL	*p*-value
(Intercept)	-3.40	0.94	0.03	-3.63	0.01	0.21	< .001
Age	0.13	0.04	1.14	3.22	1.05	1.23	.001
Black	1.10	0.46	3.01	2.42	1.23	7.35	.016
Gender (Female)	0.15	0.36	1.16	0.42	0.58	2.34	.675
Violent/ Threatening Behaviour	1.74	0.39	5.73	4.48	2.67	12.29	< .001
Substance Abuse	0.36	0.34	1.44	1.07	0.74	2.78	.284

Model $X^2 = 45.98$, *df* = 4, *p* < .001

Table 10. Predictors for Any Coercive Intervention (*N* =208)

	Estimate	SE	OR	*z*	95% CI LL	95% CI UL	*p*-value
(Intercept)	-3.48	0.95	0.03	-3.68	0.01	0.20	< .001
Age	0.14	0.04	1.15	3.40	1.06	1.24	<.001
Black	1.00	0.46	2.72	2.19	1.11	6.63	.028
Gender (Female)	0.01	0.36	1.01	0.04	0.50	2.04	.968
Violent/ Threatening Behaviour	1.61	0.39	5.01	4.14	2.34	10.74	< .001
Substance Abuse	0.50	0.34	1.64	1.46	0.84	3.18	.144

Model X^2 *= 43.52, df = 4, p < .001*

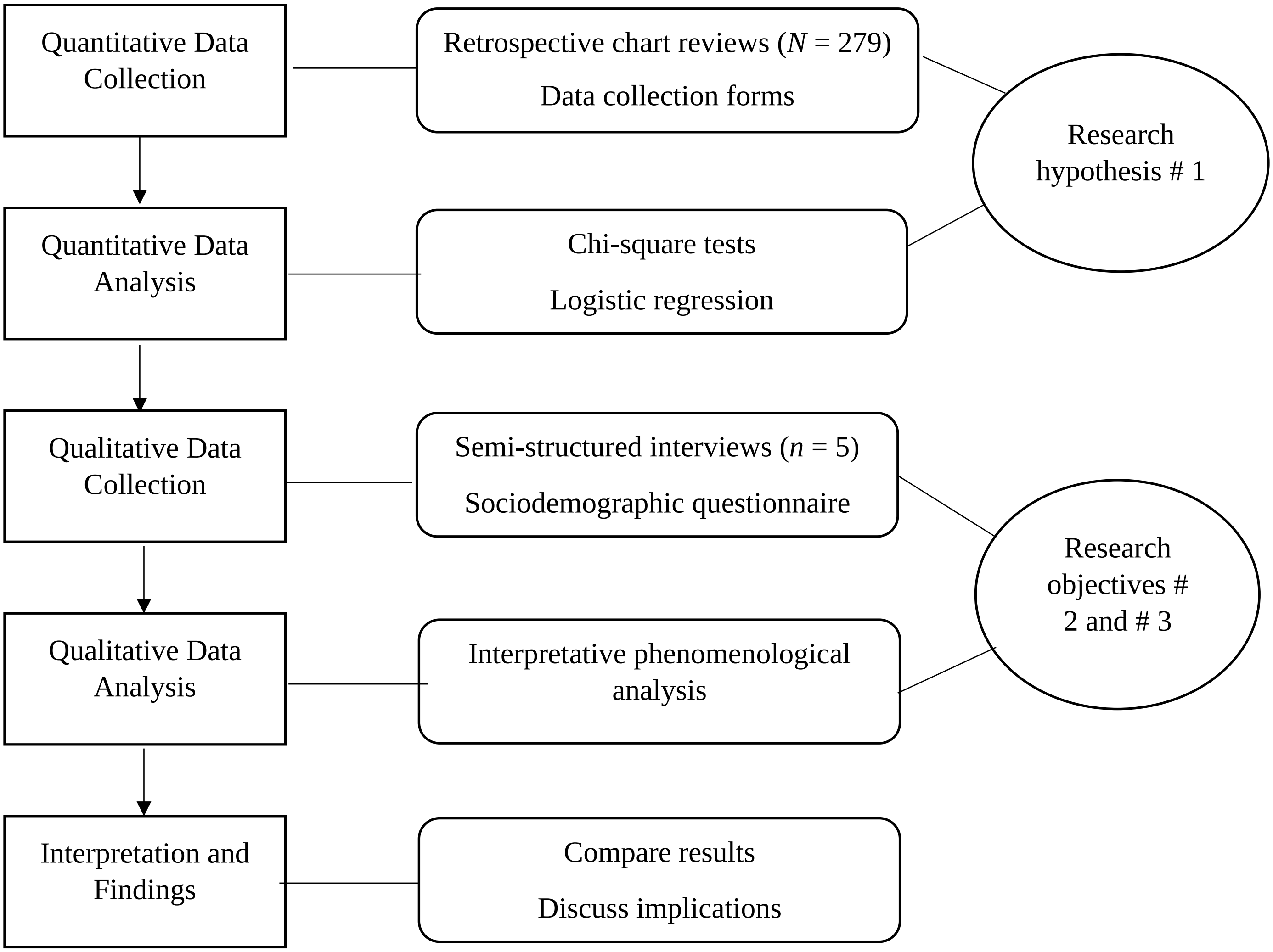
Table 12. Summary of Themes by Participant.

Theme	Participant				
	1	2	3	4	5
Sense of Confusion	X	X	X	X	X
Forced Medication	X	X	X	X	X
Feelings of Loneliness	X	X	X	X	X
Police Contact		X	X	X	X
Discrimination & Prejudice	X		X		X
Feeling Unheard	X			X	
Mistrust	X		X		
Powerless	X		X		

X = Theme reported by the participant

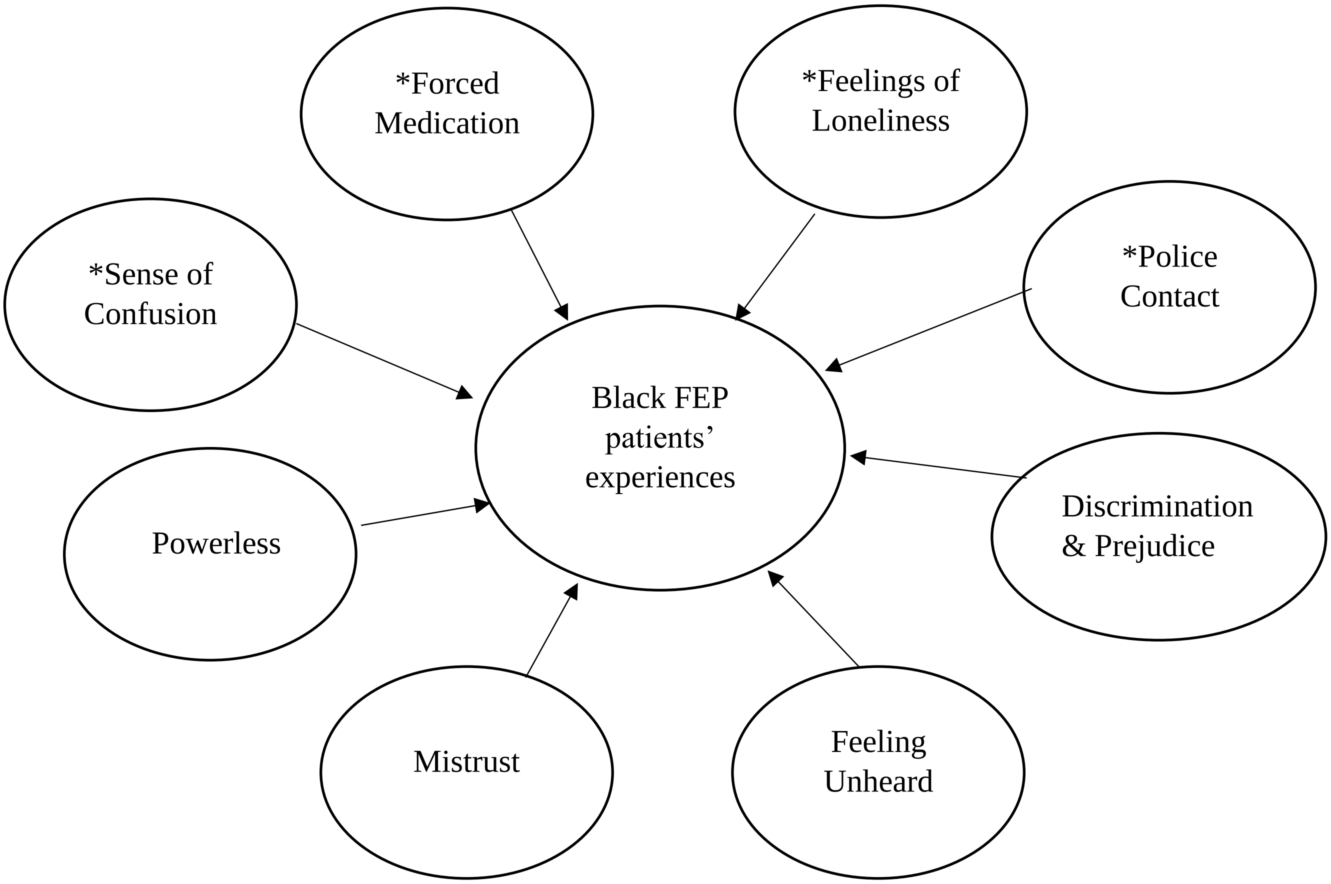
Figures

Figure 1. Sequential explanatory design.



Note. The research objectives of the study are: 1) to determine whether Black first episode psychosis (FEP) patients are at a higher risk of coercive referral and coercive intervention than non-Black FEP patients, 2) to examine the experiences of Black FEP patients who underwent coercive interventions, and 3) to explore how these experiences may have influenced help-seeking behaviours.

Figure 2. Summary of Themes



Note. (*) denotes a core theme.

Appendix I.

Data Abstraction Form

A. General Information

Item	Information	Coding
Subject Number		
Subject U-Number		
Date of FEPP referral (dd/mm/yy)		
Still active to follow-up	0 = No 1 = Yes 2 = Not noted	
Date of chart review (dd/mm/yy)		

B. Sociodemographic Information

Item	Information	Coding
Date of Birth (dd/mm/yy)		
Gender	0 = Male 1 = Female 2 = Other Specify 3 = Not noted	
Marital Status	0 = Single 1 = Married or cohabiting 2 = Separated or divorced 3 = Widowed 4 = Not noted	
Education Level (completed)	0 = Elementary school 1 = High school 2 = CEGEP 3 = University or college 4 = Not noted	
Current Employment	0 = Unemployed 1 = Employed 2 = Not noted	
Living situation	0 = Living with family or friends 1 = Living alone in a private residence 2 = Living in residence (e.g., group home) 3 = Homeless	

	4 = Other living situation Specify 5 = Not noted	
Country of Origin	0 = Canada 1 = Other country Specify 2 = Not noted	
Length of stay in Canada (years)	Specify	
Ethnicity and race	List everything mentioned in the chart	
Indicated "Black" in chart	0 = No 1 = Yes	
Religion	0 = Jewish 1 = Protestant 2 = Roman Catholic 3 = Greek Orthodox 4 = Buddhist 5 = Muslim 6 = Hindu 7 = Other Specify 8 = Not noted	

C. Psychiatric Clinical Information

Item	Information	Coding
Diagnosis of psychosis	0 = No 1 = Yes 2 = Not noted If yes, describe	
Severity of psychosis *Main symptoms of psychosis - hallucinations, delusions, paranoid ideation, thought disorder, and bizarre behaviour*	a) Hallucinations 0 = No 1 = Yes 2 = Not noted b) Delusions 0 = No 1 = Yes 2 = Not noted c) Paranoid ideation	

Associated symptoms or characteristics of psychosis - diagnosis of psychosis by the emergency psychiatrist, hospital discharge diagnosis of psychosis, blunted affect, poor insight, disorientation, poor judgement, self neglect, poor motivation, impulsive behaviour, violent/threatening behaviour, history of recent antipsychotic use, agitation, and grandiosity	0 = No 1 = Yes 2 = Not noted d) Though disorder 0 = No 1 = Yes 2 = Not noted e) Bizarre behaviour 0 = No 1 = Yes 2 = Not noted f) Diagnosis of psychosis by the emergency psychiatrist 0 = No 1 = Yes 2 = Not noted g) Hospital discharge diagnosis of psychosis 0 = No 1 =Yes 2 = Not noted h) Blunted affect 0 = No 1 = Yes 2 = Not noted i) Poor insight 0 = No 1 =Yes 2 = Not noted j) Self neglect 0 = No 1 = Yes 2 = Not noted k) Poor motivation 0 = No 1 = Yes 2 = Not noted	

	l) Impulsive behaviour 0 = No 1 = Yes 2 = Not noted m) Violent/threatening behaviour 0 = No 1 = Yes 2 = Not noted n) History of antipsychotic use 0 = No 1 = Yes 2 = Not noted o) Agitation 0 = No 1 = Yes 2 = Not noted p) Grandiosity 0 = No 1 = Yes 2 = Not noted	
Substance abuse	0 = No 1 = Yes 2 = Not noted	
Suicide ideation	0 = No 1 = Yes 2 = Not noted	
Duration of untreated psychosis (estimate – first psychotic symptoms to first antipsychotic prescription)	Specify	
Mode of Referral to FEPP	0=Self referral 1=Family referral 2=GP referral 3=Ambulance/police referral Describe 4=Referred by the court 5=Other Describe	

D. Involuntary admission and coercive intervention measures

Item	Information	Coding
Garde Preventive	0 = No 1 = Yes 2 = Not noted If yes, describe	
Garde Provisoire	0 = No 1 = Yes 2 = Not noted If yes, describe	
Garde En Etablissment	0 = No 1 = Yes 2 = Not noted If yes, describe	
Length of GEE (days)	Specify	
TAQ involvement	0 = No 1 = Yes 2 = Not noted If yes, describe	
Outpatient Court Order (Forced Treatment Order)	0 = No 1 = Yes 2 = Not noted If yes, describe	
Length of Court Order (months)	Specify	
Police Contact	0 = No 1 = Yes 2 = Not noted If yes, describe	
Immigration coercive measures	0 = No 1 = Yes 2 = Not noted If yes, describe	
Was the patient ever placed in detention?	0 = No 1 = Yes 2 = Not noted If yes, describe	
Was Youth Protection involved?	0 = No 1 = Yes 2 = Not noted If yes, describe	
Seclusion was used	0 = No 1 = Yes 2 = Not noted If yes, describe	

Appendix II.

Sociodemographic Questionnaire

Please do not write your name on this form. It will be stored separately from other information that you complete during this study and will not be linked with your responses in any way. The information will allow us to provide a description of the sample.

For the following items, please select **one** response that is most descriptive of you and fill in the blank as appropriate. If you have any questions, please ask the researcher Sommer Knight.

Age: _______________

Gender:
- ☐ Male
- ☐ Female

You don’t have an option that applies to me. I identify as
(please specify) ______________________

Marital Status:
- ☐ Single
- ☐ Married or cohabiting
- ☐ Separated or divorced
- ☐ Widowed

Education Level (completed):
- ☐ Elementary school
- ☐ High school
- ☐ CEGEP
- ☐ University or college

Current Employment:
- ☐ Unemployed
- ☐ Employed

Living Situation:
- ☐ Living with family or friends
- ☐ Living alone in a private residence
- ☐ Living in a residence (e.g., group home)
- ☐ Homeless

Country of origin: ______________________________________

Ethnicity and race: _____________________________________

Religion: ___________________________________

Thank you for your time.

Appendix III.

Interview Guided Questions

COERCIVE INTERVENTION INTERVIEW QUESTIONS

Prior to the interview, the student researcher will introduce herself, explain the study and obtain informed consent. Participants will be asked if they have any questions about the study or the student researcher before the interview begins.

OPENING

1) How were you referred to FEPP?
2) Have you ever been hospitalized for psychosis?

ADMISSION/REFERRAL

3) Tell me how you first came to the hospital.
4) How do you feel about your experience coming to the hospital?
5) How did that hospital admission affect you?
6) Why do you think that happened to you?

TREATMENT

7) Tell me about the treatment you received in the hospital.
8) How do you feel about the treatment suggested by your doctor?
9) What types of help or treatment were most useful? Not useful?

IDENTITY

10) What do you think about this statement?
    Based on my background or identity, my quality of care is worse.

HELP-SEEKING BEHAVIOURS

11) How has your past experience with mental health services influenced how you obtain care?
12) What would have been more helpful for you in the past as you sought care?
13) What would be more helpful to you now?

IMPROVEMENTS

14) How has it been for you coming to the FEPP program?
15) How do you feel that your care been so far by the FEPP team?
16) What type of care do you wish you could have received?
17) Is there anything else you'd like to add about your FEPP experience or any other aspect of your care?