Organisations’ contributions to the 2018 review of the Mental Health Act: Social processes, racial disparities and the role of stakeholders

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For my Auntie Vicky and my grandparents, Mary and Emmanuel Baah, without your kindness, advice and generosity, I wouldn't be where I am today.

You are all forever in my heart.

"Mone wiase kanea. Kurow a ɛda bepɔw so no ntumi nhintaw. Wɔnnsɔ kanea mfa nsie, na mmom wɔde si petee mu na ahyerɛn ama wɔn a wɔwɔ ofi no mu no nyinaa." Mateo 5:14-15

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ABSTRACT

Aims: The aim of the present research was to study stakeholders' experiences of the written and verbal consultations during the 2018 review of the Mental Health Act, in particular how issues of race were explored.

Background: There are longstanding racial inequalities within the mental health system. One of the most concerning areas of inequality is the disproportionate use of the Mental Health Act. There have been several policies and legislative attempts to address racial inequities in society and the mental health system, however many have failed to change the material condition for people from ethnic minority backgrounds within mental health services. The 2018 review of the Mental Health Act aimed to address the disproportionate detention rates for people from ethnic minority backgrounds. The Government appointed an independent advisory panel to conduct consultations with key stakeholders to advise on recommendations for review.

Rationale: Due to previous policy failures to adequately reduce racial inequality within mental health services and in the application of the Mental Health Act, the study aimed to explore stakeholders' experience of the Mental Health Act review process, with particular attention to how race was addressed within consultations.

Methodology: Semi-structured interviews were conducted with eight key stakeholders based in the UK. A critical realist thematic analysis was used to analyse participants' experiences.

Results: Three main themes were identified, "It's a charade": power and influence in the review process; "This is how the political system works": power enacted in the design of the review and Elements in an ideal consultation.

Conclusion: Stakeholders highlighted how power operated within the review process. This impacted their ability to consult, how issues of race were subsumed and ignored and how organisational and structural changes were needed to improve the stakeholder consultations. The study identifies key implications for future policy development, professional training and further research.

Key Words: Mental Health Act, Racial Inequality, Policy, Policy Process, Policy Reform, Stakeholder Consultation, Legislative Reform.

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1. INTRODUCTION

1.1 Chapter Overview

The aim of this chapter is to provide background for the present study in relation to relevant literature. Firstly, a summary of the key policy and legislative attempts made to reduce racial inequity will be provided. Secondly, a conceptual framework will be presented to interrogate the structural, institutional, and interpersonal impact of racism. Thirdly, the current inequities within the mental health system will be outlined in relation to racial and ethnic disparities in access, treatment, and clinical outcomes. Lastly, a brief history of Mental Health Act reforms and the contemporary use of the Act will be presented. Reference will be made to racial and ethnic disparities in the use of the Act and the context of the 2018 Mental Health Act reform. The rationale and aim for the present research will also be outlined.

1.2 The Mental Health System and Racial Inequity

There is a longstanding history of racial inequity within the mental health system in the UK (Fernando, 2017). A report on 'Advancing Mental Health Equalities Strategy' by NHS England stipulates that the NHS is committed to reducing racial and ethnic disparities in mental health care (NHS England, 2020). There is a specific emphasis on the need to tackle racism as part of the goal of achieving equality in care (NHS England, 2020). While the report points to a goal of equality, Mangalore and Knapp (2006) have argued that services should strive for equity over equality, as aiming for 'equal' services fails to provide an understanding and corrective for the systemic differences across racial groups. In relation to the mental health system, this applies to inequities found in service access, experiences in care and treatment, and clinical outcomes (Bignall et al., 2019).

1.3 Key Legislation and Policy Attempts

The need to address racial discrimination and inequity in society and within the mental health system has been recognised in several legislative and policy documents and public health initiatives (Ashe, 2021). This section provides a summary of key legislation and policy.

1.3.1 Human Rights Law

The Human Rights Act (HRA) 1998 came into force in 2000 and set out fundamental rights and freedoms in a series of articles. The Act incorporates rights contained in the European Convention on Human Rights (ECHR) into the British domestic law (Council of Europe, 1952). This requires all British domestic law, including the Equality Act, the Mental Health Act and Mental Capacity Act, to comply with the HRA. In addition, all public bodies and staff, including the NHS, are required to act as duty bearers to respect and uphold human rights. The Act also provides individuals within the UK the legal basis to raise and claim against human rights breaches through the British Court or raise complaints to public authorities.

England was one of the first member states to ratify the ECHR, which consists of 14 articles. Notable articles within the Act include: Article 2, the right to life, which also requires the state to investigate deaths in state custody; Article 3, freedom from torture and inhumane or degrading treatment, which includes serious physical or psychological abuse in health or care settings; and Article 14, protection from discrimination, including racial discrimination. Whilst Article 14 holds importance, it is not a free-standing right, meaning claimants have to prove that discrimination has failed to protect other rights in the Act.

The relationship between mental health and human rights is of particular importance as coercive practices which exist within mental health systems, practices and laws can infringe human rights. The differential and disproportionate treatment and outcomes for people from ethnic minority backgrounds within the mental health system also presents further concerns with regards to breaches of equality and human rights. Article 21(1) of the International Covenant on Economic, Social and Culture Rights outlines the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (United Nations, 1976). The obligation for Governments and States to work to eliminate racial and ethnic discrimination within institutions is embedded in the United Nations Convention on the Elimination of all Forms of Racial Discrimination (United Nations, 1966).

1.3.2 The U.K. Race Relations Act and Equality Act

The Race Relations Act 1965 was the first law to provide legal protection against racial discrimination in the UK. The law was introduced in a context of increased migration following World War II which led to a rise of racism within the UK. Whilst the Race

Relations Act 1965 was the first law of its kind, Peplow (2017) argues that the legislation was disguised as a ‘package deal’, and provided a way for the Government to pass harsher immigration laws while appearing to combat racial discrimination.

The Act aimed to prevent discrimination on the ground of colour, race or ethnic or national origins in places of public resort. Later revisions aimed to broaden areas of protection, for example, to prevent discrimination within employment and access to housing. Following the MacPherson inquiry into Stephen Lawrence's death, the Act expanded to all public bodies, notably hospitals and police, as well as the private sector (Siva, 2009). However, this was met by a lack of commitment from the NHS to meet the legal obligations outlined under the Act, mainly to adequately record ethnicity data to enable a better understanding of inequalities within health services (Siva, 2009).

Whilst there was an acknowledgement that legalised protection was needed against racial discrimination, the Act was universally criticised for ineffectively protecting or changing the conditions for those subject to racial discrimination. The Act had been criticised on two levels, firstly, for the failure to explain how racial inequalities persist and proliferate; and secondly, for the lack of legal enforcement to ensure the legislation tackles and protects against racism (Anwar et al., 1999). There was a recognition that the Act's benefits were perhaps more symbolic and provided legalised groundwork to challenge inequality (Banton & Michael, 1985).

The Race Relations Act was updated in 2000 and eventually replaced by the Equality Act 2010 (Fredman, 2011). The Equality Act 2010 broadened areas of discrimination by providing legal protection based on nine protected characteristics, such as gender, race, age, and disability. Although the Equality Act enabled broader thinking to protect other areas of marginalisation, its introduction has been criticised as a way of no longer prioritising issues of racial discrimination and subsuming race under a broader notion of equality and diversity (Kapoor, 2013).

1.3.3 Key Policies Addressing Racial Inequity in Mental Health

1.3.3.1 Inside Outside Report

The Inside Outside report was created in consultation with ethnic minority groups to produce a framework to enable mental health services to “deal with the institutional racism that is built into organisational culture and professional practice” (Sashidharan, 2003, p. 24). It was the first report of its kind to explicitly acknowledge the existence of institutional racism within mental health services. The report recognised the policy need to reduce and address inequities in outcomes for ethnic minority groups and made specific recommendations, including the need for workforce development, research and governance (Fitzpatrick et al., 2014). Although the recommendations in the report were welcomed, many were disappointed with subsequent developments, particularly how the policy implementation document, Delivering Race Equality (DRE), shifted the focus away from racism (Bhui et al., 2004).

1.3.3.2 Delivering Race Equality Action Plan

The DRE programme was a five-year plan, launched in 2005 and aimed to improve services for people from ethnic minority groups. The programme was initiated by the Department of Health as part of the department's equality and human rights strategy (Wilson, 2010). The programme also aimed to promote compliance with the Race Relations (Amendment) Act 2000 within NHS trusts through training in 'race relations' (Bhui et al., 2004). The plan drew on key publications including the Inside Outside report and the independent inquiry into the death of David 'Rocky' Bennet, who died in a psychiatric unit after he was restrained by staff (Wilson et al., 2009). Whilst the DRE was expected to act as an implementation guide to the Inside Outside report, the emphasis moved away from the report's anti-discrimination and anti-racist emphasis to focus on strategic and organisational change (Bhui et al., 2004). The DRE document identified three main 'building blocks' for service change: (a) appropriate and responsive services, (b) community engagement, and (c) better information.

The practicalities of the DRE were largely complex in terms of scale, structure and delivery (Fitzpatrick et al., 2014). Although the plan was created and monitored by Governmental ministers and external groups, the idea was to create Community Development Workers (CDW) to action and deliver the goals of the DRE. The CDW role was largely criticised as unsustainable and unsupported. Workers, in particular, raised that they had little power to make change locally (Fitzpatrick et al., 2014). A five year review of the DRE conducted by the Department of Health acknowledged that although progress was made in some areas, the ability to monitor the impact of the DRE was largely affected by variability in the availability, collection and quality of data (Wilson, 2010). Failures of the DRE were largely attributed to organisational and political difficulties, in addition to the shift from addressing racial inequity and institutional racism highlighted in previous documents (Bhui et al., 2004). The failure was particularly evident in the 2010 'Count Me in Census' conducted by the Care Quality Commission (CQC), a report tasked to monitor ethnicity data in inpatient and learning disability services alongside and as part of the DRE. The CQC highlighted that three areas of the DRE's goals; rates of admission, detention under the MHA and seclusion, had not improved since the creation of the DRE (Care Quality Commission, 2011).

A report by the service user-led group, 'Rights and Wellbeing of Racialised Groups' (RAWOrg), described the document as an insufficiently resourced and unsustainable attempt by the Government and other bodies to deliver racial equity (RAWOrg, 2010). They criticised the individualised focus by the Government to locate the problems within ethnic minority groups rather than in systems and institutions. Instead, they highlighted several issues within mental health systems including institutional racism in society and services, poor research and practice, and lack of commitment by Government and stakeholders to deliver on promises made to policy consultees (RAWOrg, 2010). Many of these issues were highlighted in the original Inside Outside report. Since the DRE, there has been no government policy and action plan of the same scale focused on addressing racial inequities within the mental health system (Fitzpatrick et al., 2014). Fitzpatrick et al. (2014) highlight that due to economic austerity, limited funding, and the shift to localising service delivery; civil servants, senior managers and front-line service deliverers are constrained in their ability to enact change.

1.3.3.3 Joint Commissioning Panel for Mental Health

Drawing on the recommendations from the DRE the Joint Commissioning Panel for Mental Health (JCPMH) issued guidance for groups at risk of experiencing inequalities in care (Joint Commissioning Panel for Mental Health, 2014). This included specific guidance for commissioners of mental health services on how to commission equitable services for people from ethnic minority communities (Joint Commissioning Panel for Mental Health, 2014). There was an implication that the JCPMH guidelines would lead to a substantial monitoring of mental health service data and improve service access and clinical outcomes for people from ethnic minority backgrounds (Beck & Naz, 2019). However, a report by the National Collaborating Centre for Mental Health (2019) highlighted the limitations of guidance documents and advocated for a more targeted approach to support the delivery of more equitable mental health care.

1.3.4 Policy Effectiveness

Nazroo et al. (2020) note that legislative and policy attempts to reduce racial inequity over the last 50 years have led to little protection or change for the social and material conditions for ethnic minority groups in the UK. They suggest that inequalities persist because policymakers often distance themselves from social issues (Nazroo et al., 2020).

In 2020, the Stuart Hall Foundation conducted a report to review policy recommendations related to race and inequality (Ashe, 2021). The report revealed 589 different recommendations made by 13 previous race and inequality reports and commissions between the period of 1981 and 2017, and concluded that despite several recommendations racial inequalities persist across all areas of life such as, health, education, poverty and housing (Ashe, 2021).

It is unclear whether this is due to resistance within the policymaking process or in the application of policy. The aforementioned legislative and policy attempts, however, indicate a number of areas of concern, such as, failure to adequately consult or attend to issues and explanations for racial and ethnic disparities raised by those from ethnic minority groups, failure to adequately name and address racism, and the gaps between policy recommendations and action which leads to poor implementation.

1.4 Conceptual Framework - Racism and Mental Health

In recent years, there has been an increasing acknowledgement of the impact of racism on mental health and the mental health system. Despite this acknowledgement, racial and ethnic disparities within mental health care persist. Fernando (2017) argues that there is often a lack of understanding of the complex and multi-faceted way racism prevails within society and systems. He notes that these harmful practices and differential conceptualisations of distress stem from histories of slavery and colonisation and are entrenched in socio-political systems and mental health practices. Fernando highlights how the history of racialisation, such as the creation of racial hierarchies as a tool for exploitation and a justification for harm, provides context for modern-day societal structures and knowledge production. Many of these structures uphold ideas of racialised inferiority and enable society to justify the harm and dehumanisation of racialised minorities (Fernando, 2017). For example, racialisation in science, created historically to reify notions of racial superiority and substantiate segregation, continues to underpin modern-day psychological and psychiatric practice, e.g. IQ tests (American Psychiatric Association, 2021; American Psychological Association, 2021; Ben-Cheikh et al., 2021; Patel, 2003). These ideas are further embedded in institutions, such as schools, Governments, healthcare, and mental health systems, and reinforced in individuals and communities. As a consequence, a process of Whiteness occurs, whereby systems, laws and spaces are created and reproduced to structurally privilege those who belong to White ethnic groups through the subjugation and exclusion of those who are racialised as 'non-White' (Neely & Samura, 2011). Due to the pervasiveness of racism, Nazroo et al. (2020) emphasise the need to move away from arguments questioning the existence of racism and stress the need to shift understanding to how racism is enacted to create inequity.

Nazroo et al. (2020) argue that approaches which focus on individualised risk factors "pay insufficient attention to the ways in which these risk factors, and institutional responses to them, are shaped by processes related to racism" (p. 263). Nazroo and colleagues (2020), instead, propose a structural, institutional, and interpersonal framework to outline the systemic ways racism impacts mental ill-health and all aspects of the mental health system. They acknowledge that these three categories are connected as well as discrete, and highlight the importance of not separating racism or the processes of racialisation from its historical and political roots – that is, created through histories of enslavement and colonisation. They emphasise that race and ethnicity remain key determinants for social location, status and power (Nazroo et al., 2020).

Analysing structural, institutional, and interpersonal elements provides a framework to identify the number of ways racism operates within society and the mental health system, leading to disparate socioeconomic disadvantage, differences in diagnosis, poor treatment, and inadequate policy solutions. The conceptual framework by Nazroo and colleagues has been used below to understand and explain the racial inequities within the mental health system. Other theoretical frameworks such as critical race theory (CRT) were considered as CRT also enables an examination of the structural nature of racial discrimination, inequality and racism (Savas, 2014). CRT posits race as a social construction and consequently racism is enacted through social and political disempowerment of racialised minority group as a way to maintain social hierarchies (Savas, 2014). While a fundamental tenet of CRT involves a multi-axis analysis of intersecting systems of power, such as the interaction between race, gender and class, there is a limited exploration of the interaction between race, mental distress and policy within literature (Brown, 2008; Keating, 2016). As a result, Nazroo and colleagues' model has been used due to the specific focus on interrogating the levels of racism within a UK context and the impact on mental ill health and policy. Using this model is not necessarily the only way of understanding racism, but one way to conceptualise the interconnected ways racism in society is reproduced within the mental health system (Nazroo et al., 2020).

1.4.1 Structural Racism

Nazroo and colleagues (2020) use structural racism as a way to understand the disparate ways in which people from ethnic minority groups are disadvantaged economically, politically, and culturally. Namely, the further link between social disadvantage and poor mental health. There is consistent evidence that people from ethnic minority backgrounds, particularly Black African, Black Caribbean, Pakistani, and Bangladeshi ethnic groups, are disproportionately subject to poorer social conditions, in addition to racism and discrimination (Gwaspari et al., 2011).

In 2017, findings from the UK Government's Race Disparity Audit demonstrated entrenched racial inequality across several areas, including housing, employment, health, policing and education (Cabinet Office, 2017). Unequal distribution of money, power, and resources, for example, in housing and education, has been evidenced to have implications on physical and mental health. These issues are often multifaceted and there are variations depending on which minority community/population is under consideration.

A report by the Runnymede Trust highlights the lifelong implications of social inequality, mainly income inequality, on ethnic minority groups (Khan, 2020). For example, the report found that people from various ethnic minority groups suffer more in the labour market, where they have poorer access to employment, lower wages, and poorer progression. These factors have implications for access to adequate housing and safe neighbourhoods, which in turn can impact schooling and lead to poorer outcomes for their children, creating a further entrenched generational disadvantage. Even when ‘protective’ factors are in place, racial inequities and experiences of racism are also found. For example, although ethnic minorities are more likely to live in some of the most deprived boroughs in England, Black people specifically are still more likely to experience poorer job prospects and poorer housing regardless of whether they are living in deprived or affluent areas (Khan, 2020). Similar outcomes have been found when education level is matched, Black people are more likely to be unemployed even after completing their degree from a Russell Group university (Lessard-Phillips et al., 2014).

The collective and fatal impact of structural harm experienced by people from ethnic minority backgrounds is also evidenced within healthcare systems, housing, and legislation.

For example, recent COVID-19 data has shown higher rates of COVID-19 related deaths for people from ethnic minority backgrounds compared to White British people (Otu et al., 2020). Additionally, the Grenfell fire and the Windrush scandal highlight the tragic impact of poor housing conditions and policies created to uphold the continual conditionality of citizenship for racialised and minoritised people (Perera, 2019). In many of these cases, such as the COVID-19 deaths, Windrush and Grenfell, there is a Governmental failure to acknowledge structural racism as a factor or provide justice or reform (Doyle & O'Brien, 2019).

A number of these social determinants are also closely linked to poorer mental health, for example, income inequality has been linked to higher rates of a schizophrenia diagnosis (Burns et al., 2014). While higher levels of adverse childhood experiences, such as poverty and parental incarceration, are more likely to have negative consequences on an individual's mental health (Cromby et al., 2013). The cumulative impact of disadvantage and the combination of numerous social disadvantages can lead to a risk of higher psychological and physical distress, and have implications for diagnosis, treatment outcomes and recovery (World Health Organization, 2014). This idea is supported by Mangalore and Knapp (2012) who reviewed income related inequalities for people with common mental health disorders and found that the impact of lower income was worse for people with mental health difficulties from Black African, Black Caribbean, Pakistani and Bangladeshi ethnic groups, concluding that even when income is low, race as an added factor can increase experiences of distress.

1.4.2 Interpersonal Racism

Nazroo et al. (2020) characterise interpersonal racism as a relational and interactive way racism impacts individuals and communities. Whilst all forms of racism can be seen to have a relational aspect, this characterisation is helpful in pointing to the interpersonal experiences of racism, such as racial violence and hate crimes.

In the UK, hate crimes have doubled within the last five years and although racial violence is largely under-reported, the majority of reported hate crimes are race-based (Home Office, 2019a). The cumulative exposure to racial discrimination has been found to have long-term and have detrimental consequences on the mental health of ethnic minorities in the UK (Wallace et al., 2016). A study by Hackett et al. (2020) found that racial discrimination was associated with higher levels of psychological distress, lower levels of life satisfaction, and poorer physical and mental functioning. Specific links between experiences of racism have also been demonstrated in research investigating experiences of psychosis (Karlsen et al., 2005). For example, research by Karlsen and Nazroo (2002) found that the prevalence of psychosis was three times higher for people who reported experiences of racist verbal abuse, and almost five times higher for experiences of racist physical abuse.

While individual and community experiences of racism have detrimental consequences on mental health, Nazroo et al. (2020) highlight the importance of understanding how interpersonal racism is framed by structural racism, and equally interpersonal actions and ideals act as a way to uphold and actualise structural and institutional forms of racism. The conceptualisation of the interconnectedness of how racism operates enables a shift from the fixation that racism is only due to individual actions (Ahmed, 2012).

1.4.3 Institutional Racism

Hui et al. (2020) note that racism not only impacts an individual's mental distress but also operates in mental health systems and is evident in pathways of care, such as access, support, diagnosis, and recovery. This notion of racism as an institutional structure was first coined by Carmichael and Hamilton (1967), who identified racism, inequity and exploitation within organisational and institutional contexts. Speaking from an American perspective, they state that institutional racism:

> Originates in the operation of established and respected forces in the society. It relies on the active and pervasive operation of anti-black attitudes and practices. A sense of superior group position prevails: whites are 'better' than blacks and therefore blacks should be subordinated to whites. This is a racist attitude and it permeates society on both the individual and institutional level, covertly or overtly. (Carmichael & Hamilton, 1967, p. 21).

The term was adapted and seemingly used by Sir William Macpherson in a UK context following a public inquiry into the death of Stephen Lawrence. The report acknowledged institutional racism within the criminal justice system and other public bodies and demanded action from institutions such as the NHS (MacPherson, 1999). Examples of institutional forms of racism are evident in disparities within the mental health system, such as, compulsory pathways to care (Memon et al., 2016), disproportionate rates of ‘severe’ mental health diagnoses (Kirkbride et al., 2012) and disparities in access to care (Bignall et al., 2019).

Using disproportionate psychosis diagnoses as an example, Nazroo et al. (2020) stipulate that research and policy focus heavily on individual predictors and incident rates. This leads to an inadequate explanation or understanding of racial and ethnic disparities. While explanatory models for the over-representation of psychosis diagnoses, such as schizophrenia, are complex. Fernando (2017) argues that they are intrinsically linked to how diagnoses are made and how institutions and society have played a key role in the racialisation of psychosis as a ‘Black man’s disease’. He puts forward the notion that the Western racialisation of the psychosis diagnosis is compounded by the added stress and discrimination experienced in society by ethnic minority groups as a result of racism (Fernando, 2017).

Some studies have attempted to highlight how institutional and scientific racism operates within medical and psychological professions, specifically how diagnosis is underlined by racism and is culturally bound. Research by Hickling and Rodgers-Johnson (1995) found the prevalence rate of a schizophrenia diagnosis in Jamaica was more comparable to the general UK population as opposed to the rates of the Black Caribbean population in the UK. Similar incidence rates were found in Trinidad and Barbados (Bhugra et al., 1996; Mahy et al., 1999). These findings were shown even with the use of Western diagnostic criteria and in countries with histories of being subject to Western imperialism and colonialism (Hickling & Rodgers-Johnson, 1995).

Subsequent studies have further questioned biases in diagnosis. For example, one study found Black men in the UK were diagnosed with psychosis at a slightly lower rate when the psychiatrist was from a Jamaican background (Hickling et al., 1999). In contrast, a large scale study investigating high incidence rates of psychosis in African-Caribbean populations found elevated rates in comparison to White ethnic groups, even when the reviewers were blinded to ethnicity (Morgan et al., 2006). However, Nazroo et al. (2020) note that coded language can be used in case notes and influence racial stereotyping. Interestingly, people from ethnic minority backgrounds are more likely to present different explanatory models for their diagnoses. In a study by Chakraborty et al. (2009) Black patients reported that their psychiatric distress was due to racial discrimination in psychiatric services and society as a whole, while White service users felt their experiences of discrimination was based on their mental health diagnosis as opposed to their race or ethnicity.

1.4.4 Summary

In this section, a conceptual framework has been provided to understand how racism and racial discrimination impacts the social conditions of racialised minorities on a structural, institutional and interpersonal level. This framework provides a way of conceptualising and contextualising racial inequities within the mental health system. Specifically, the theoretical gaps within literature and policy. The next section provides a broad narrative overview of the literature related to the various racial and ethnic inequities within the mental health system.

1.5 Narrative Literature Review - Racial Inequities in the Mental Health System

A literature review was conducted below to gain a broad overview and understanding of the racial inequities within the mental health system. Due to the scope of this aim, and the breadth of the literature, a narrative review was conducted. Lloyd (2013) also suggests that a narrative approach is appropriate when a wide range of methodologies are employed in the reviewed literature.

1.5.1 Strategy for Narrative Literature Search

An inclusive and systematic approach was taken to identify relevant literature and papers on racial inequities within the mental health system. Searches were conducted on the following databases: Academic Search Complete, CINAHL Plus, PsychINFO and Science Direct. Reference lists and official documents and reports were also searched to find grey literature. Multiple search terms were used, including ‘BAME’, ‘minority ethnic’, ‘Black’, ‘African’, ‘Caribbean’, ‘Asian’, ‘mental health’, ‘disparities’, disproportionate’, ‘inequality’ and ‘inequity’. The full list of search terms can be found in Appendix A. Only studies conducted within the UK in the English language were included. Through this method, 482 papers were initially accessed. Upon review, 30 papers and reports were identified as relevant. The papers and reports represent a broad range of methodologies, such as Governmental reports, organisational documents, and qualitative and qualitative papers.

The 30 papers included in the review were read and analysed and organised into key themes below. A table summarising the included literature can be found in Appendix B. The papers and reports can be split into three themes that relate to the search aims. These themes are inequalities in access, treatment, and outcomes.

1.5.2 Access Routes

People from ethnic minority backgrounds often come into contact with secondary care services later or when mental health needs are greater, leading them to access crisis pathways and come into contact with coercive ends of the system (Memon et al., 2016). Bignall et al. (2019) suggests that barriers to primary care access, i.e. to GPs, may explain why these disparities persist.

People from Black African or Caribbean ethnic groups are less likely to contact their GP and more likely to be seen by emergency services (Ghali et al., 2013). However, in cases where they do try to access early help services, they are less likely to be referred for psychological therapy (Bignall et al., 2019; Mercer et al., 2019), or prescribed anti-depressants (Schofield et al., 2016). A study by Johnson and Weich (2010) found that prior to accessing an Early Intervention Psychosis (EIP) service, half of the Black male participants had consulted their GP, yet none were referred to a mental health service. Furthermore, families felt they had to advocate on their behalf to request access to services, highlighting a lack of recognition of needs (Johnson & Weich, 2010).

Similar findings have been observed for people from South Asian and Chinese ethnic groups who have also been found to come into contact with services much later; however, in contrast to Black African and Caribbean ethnic groups, they have a lower uptake of secondary care psychiatric services (Bansal et al., 2014; Kapadia et al., 2018). Previous reviews on help-seeking behaviours in South Asian communities attribute cultural and religious influences on conceptualisations of distress and alternative coping strategies as reasons for lack of service contact (Anand & Cochrane, 2005). However, Prajapati and Liebling (2021) suggest that studies on access often neglect the ways healthcare systems perpetuate under-utilisation through their failure to address institutional racism and ethnic disparities. For example, differences have been highlighted in early pathways of help, such as primary care contact. Some studies have found that although people from the South Asian ethnic groups are more likely to consult their GP, they are still less likely than White clients to have their mental health needs recognised (Bhui et al., 2001; Commander et al., 1999). In contrast to other findings, Commander et al. (2004) found no differences between ethnic groups in appraisals of mental health and no alternative forms of help-seeking, such as traditional healers.

Morgan et al. (2004) note that pathways to care need to be understood as a social process where a range of factors, such as interactions with professionals and the role of stereotyping, can influence or act as a barrier to access. The literature emphasises a systemic failure to recognise and attend to the mental health needs of people from ethnic minority groups. Keating and Robertson (2004) suggest a cyclic process where many ethnic minority groups may hold ideas that their mental health needs will not be taken seriously or validated. Furthermore, only seeing people from their ethnic groups at more coercive ends of the system may cause people to avoid seeking help and draw conclusions about what care they may receive. This further feeds into community stigma and perceptions about mental ill-health and the mental health system (Keating & Robertson, 2004).

1.5.3 Treatment – Coercive Practices

People from ethnic minority backgrounds often report experiences of differential, poor and harmful treatment within the mental health system. Barriers to accessing care are complex and can directly affect when and where support is provided, the type of care received, and the type of diagnosis given. This ultimately has an impact on treatment: people who end up accessing care through more coercive parts of the system, e.g., through police contact or tertiary care, are systemically more at risk of harmful practices and less likely to be provided therapeutic forms of intervention (Mercer et al., 2019; Payne-Gill et al., 2021).

The use of coercive practices on people with mental health difficulties has often led to extreme physical consequences which can be fatal. An inquiry into the Independent Police Complaints Commission found people who use mental health services account for 50% of all deaths in police custody (Independent Police Complaints Commission, 2010). Between the period of 1991 to 2014, 137 people from ethnic minority backgrounds died in police custody. Approximately, 57% of these deaths were Black or Black British people, 22.6% were Asian or Asian British and 64% of people who died had known mental health problems (Athwal & Bourne, 2015). Whilst there is minimal evidence for differences between ethnic groups who have been restrained on inpatient wards (Payne-Gill et al., 2021), Black people and people with Black mixed heritage are more likely to be restrained during police contact (Care Quality Commission, 2011; Mental Health Act Commission, 2009). The numbers are concerning due to the powers of detention under section 136 of the Mental Health Act (MHA) given to police officers and the high proportion of Black people who come into contact with mental health services through the police (Rabiee & Smith, 2013). Although there is no formal data monitoring of the deaths of those detained under the MHA or in mental health inpatient wards, there have been many well-publicised cases of Black service users, such as Olaseni Lewis and Kingsley Burrell-Brown, who were restrained by police officers in a mental health inpatient unit and died as a result (Joseph–Salisbury et al., 2020). Many of these cases have triggered public inquiries, policy, and legislative changes.

Treatment disparities have also been found in clinical interventions. During psychiatric hospital admissions, Black patients, in particular, are more likely to be secluded and prescribed anti-psychotics; medication is also more likely to be delivered by Depot injections than other methods of delivery (Care Quality Commission, 2011; Pinto et al., 2010). Bhui et al. (2015) suggest that unproven explanatory assumptions, such as higher rates of drug use and violence, can often underlie the type of diagnoses given and have an impact on the treatment provided, both in terms of patient care and clinical intervention.

1.5.4 Outcomes

There are various explanations for the racial disparities in outcomes. However, historically, there has been poor recording of ethnicity data within the NHS (Siva, 2009). Despite current policy commitments within the NHS to improve outcome data collection, the current data still does not provide a full picture. But it does highlight several areas where ethnic minority groups have poorer outcomes, ranging from differences in clinical outcomes to patient satisfaction.

In the literature, clinical outcomes have been used as an overarching term to encompass a range of outcomes, including responses to psychological and medical intervention and recovery. Although there is little data on therapy outcomes, primary care service data indicates that Black and ‘other ethnic group’ service users have higher distress scores on therapeutic outcome measures, with scores remaining significantly higher at the end of therapy compared to White service users (Mercer et al., 2019). Unsurprisingly, research highlights that not only do White adults receive better outcomes in some psychological therapies, but they also report higher satisfaction ratings than any other ethnic group (Cabinet Office, 2017). As in primary care services, data from secondary care services suggests that Black African and Caribbean patients diagnosed with psychosis also have worse clinical outcomes and poorer service use than White patients (Morgan et al., 2017). For example, Black Caribbean service users are more likely to also re-experience symptoms than White service users. Racial and ethnic disparities also show that Black service users have higher levels of readmission, longer hospital stays and poorer medication adherence (Bruce & Smith, 2020; Newman et al., 2018).

A large-scale review of literature and evidence pertaining to racial disparities in mental health conducted by the Race Equality Foundation outlined several explanations for poorer outcomes. Whilst the report acknowledged the need for more data, higher levels of social issues experienced by ethnic minority groups, such as deprivation, isolation and experiences of racism within society and mental health care, were cited as factors contributing to poorer outcomes (Bignall et al., 2019). First-person accounts by people from ethnic minority backgrounds have also reported issues of racism, stereotyping, over-medication and lack of cultural awareness having an impact on their care (Gilburt et al., 2008; Wagstaff et al., 2018).

1.5.5 Summary

The literature review provides a broad overview of the racial inequities within the mental health system. In particular the complexities associated to the lack of access to early support services and the lack of recognition of mental health needs. When mental health services are accessed, there is a concerning number of evidence which highlights poor and harmful treatment, predominantly in more coercive ends of the system where individuals are subject to tenets of the MHA. This is compounded by poor clinical outcomes and patient satisfaction. The next section critically examines the racial disparities in the application of MHA in the context of legislative development and reform.

1.6 Racial Inequality and the Mental Health Act

The starkest area of inequality within the mental health system is the differential use of the Mental Health Act (MHA), and particular provisions within it for people from ethnic minority backgrounds, particularly those with Black African or Caribbean heritage. For example, there are disparate rates of involuntary detention and high levels of police contact prior to psychiatric admission (Memon et al., 2016). The Governmental report, on ‘Black people, racism and human rights’ highlights that “as bedrock for the application of human rights, the rule of law and, in particular, the requirement that there be just laws that are applied equally, is also relevant” (Joint Committee on Human Rights, 2020, p. 4). In some of the issues examined in this report, such as the over-policing of Black communities, the unequal application of the law is seen as at the heart of the problem and it is this that prevents human rights from being protected equally. This is particularly evident in the application of the Mental Health Act where there are increasing concerns about human rights violations and the disproportionate use of the Act on people from ethnic minority backgrounds (Akther et al., 2019; Kelly, 2016). Until 2018, the need to address racial disparities in the use of the MHA has been a longstanding area of neglect in the creation of the MHA and in past reforms which are explored further below.

1.6.1 The Mental Health Act

The Mental Health Act (MHA) 1983 (as amended by the Mental Health Act 2007), provides mental health professionals in England and Wales with the legal power to detain, assess and provide compulsory treatment (e.g., medication, electroconvulsive therapy) for people with mental health 'disorders' (Lawton-Smith, 2008). The legislation provides the legal basis for the compulsory detention for people who are considered to be “suffering from mental disorder of a nature or degree which warrants detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period” (s.22a) and are perceived as a risk to themselves or others (s.22b). Legal powers are also extended to the community, allowing professionals to continue treatment without detention and exercise power to recall patients to hospital (s.17a(5); s.17e(1)). Additionally, the Act provides the police with the emergency powers to detain those deemed as in need of immediate care and control to a place of safety, or to keep them in a safe place (s.135; s.136).

1.6.2 Historical Context of Mental Health Act Reforms

The foundations of modern mental health legislation pre-date the 14th century. However, in contrast to current legislation, early laws prioritised the governance of financial assets and permitted the monarchy authority over the estates of those deemed as 'mentally unwell' (Puri et al., 2012). Notably, the introduction of the 1713 and 1774 Vagrancy Acts saw a shift from the primary governance of land to the introduction of institutionalisation through detention. The aim was to remove those who were considered 'mad' and 'dangerous' from their communities into private madhouses, workhouses, and jails (Eccles, 2013).

The Mental Health Act was introduced more than a decade after the creation of the NHS, within the context of moving mental health care to the community and away from long-stay hospitals, and in an attempt to increase parity between mental health and physical health care (Hilton, 2016). Prior to the creation of the 1959 Mental Health Act, the post-war period saw significant changes in mental health treatment and care. The creation of the NHS transformed public healthcare and saw the inclusion of mental health hospitals within the NHS. This time period also saw the rise of psychopharmacology and psychotherapy, which furthered the notion that mental health difficulties could be 'treated' or managed and thus supported in the community (Novella, 2010). The 1959 MHA arguably set the groundwork for the endorsement of a medical model of mental health, this ideological shift in the conceptualisation of mental distress was actualised through the transference of responsibility for detention from the magistrates and legal procedures solely to professionals (Moncrieff, 2003).

Whilst the 1959 Act was credited for providing many of the principles for modern mental health legislation, Grounds (2001) notes that the Act's reputation was quickly called into question following concerns of service failure and abuses of professional power. The pressure to review the 1959 MHA rose in the 1970s and was triggered by several political and social factors, including several high profile incidents and public inquiries into poor institutional care (Turner, 2004).

Legislative reform of the 1959 MHA occurred primarily through a campaigning process, predominantly led by Larry Gostin on behalf of mental health charity, MIND (Toms, 2017). Gostin, who was highly critical of medicalism, argued for stronger legalistic criteria to prevent professional misuse and protect the rights and liberties of patients (Gostin, 1975). The 1983 MHA aimed to strengthen patients' rights in conditions where the loss of their liberty was likely. The process of reforming the 1959 Act and creating the 1983 Mental Health Act was arguably one of the first reform processes where civil society had a prominent influence prior to and during the reform. For example, despite their ongoing concerns about consent to treatment, MIND was credited for two-thirds of the changes within the final Act (Hilton, 2007).

1.6.3 Creation of the 2007 Mental Health Act

The reform of the 1983 MHA was marked by an arduous ten-year process involving divided ideological positions between the government and key stakeholders (Daw, 2007). Criticisms throughout the review and reform included concerns about the processes involved in the Governmental consultations and legislative recommendations. Additionally, in contrast to prior reforms, evidence of increasing racial disparity in the use of the Act was more widely raised. This perhaps only occurred following a decision in 1995 by the NHS to make ethnicity data collection a mandatory requirement in secondary care settings; and emphasis by the Race Relations (Amendment) Act 2000 for public bodies to remove discrimination in their practices (Psoinos et al., 2011).

In 1998, the Department of Health (DoH) announced the aim to reform the 1983 Mental Health Act, appointing an expert committee led by Professor Genevra Richardson. The Richardson committee was asked to conduct a 'root and branch' review of the MHA and address the issue of compulsory care in the community. Discussions preceding the review furthered debates that precipitated the changes to the 1983 Act, namely the increasing call to improve civil rights, deinstitutionalise care, and transform clinical services and community care. The review also occurred at a time when significant changes were being made to protect human rights. This led to one of the main areas of focus to ensure that the MHA was compliant with the European Convention on Human Rights (ECHR). The expert committee's final report was also published following the MacPherson report, one of the first public reports in the UK to highlight institutional racism. While it is unclear whether the MacPherson investigation influenced the Richardson review (MacPherson, 1999) the need to remove bias and justify legal decisions to reduce racial discrimination was briefly noted in the expert committee's final report (Peay, 2000).

Chan (2002) highlights that the request for reform in 1998 was also heavily predicated on the increasing portrayal of 'risk' and homicide investigations. Prior to the call to reform the 1983 MHA, Secretary of State for Health at the time, Frank Dobson, announced the Government's concern about patients who were 'dangerous' to themselves and others. His claims were also exacerbated by media, following reports of a small number of high-profile homicides by people diagnosed with mental health problems. One of the most notable cases at the time was Christopher Clunis (Cummins, 2020a). Many argued that the case, amongst others, was not only used to justify the overemphasis on public risk but also to amplify pre-existing racist stereotypes equating Blackness with 'madness' and danger (Neal, 1998; Paterson & Stark, 2001). His statement set the precedent for the Government's approach to minimising risk and, arguably, over-emphasising the focus on public danger. An approach that led to later recommendations highly contested by many stakeholders (Cummins, 2020a).

The latter 7 years of the review process saw a unique unification of 80 stakeholder organisations, including service user groups, professional bodies and charities, under the umbrella of The Mental Health Alliance, campaigning for changes to the Act (Butcher, 2007). The Alliance provided both verbal and written consultations and recommendations and highlighted concerns about the lack of capacity assessment and the proposals to introduce community treatment orders (CTOs). A small number of groups under the Alliance also raised issues regarding racial discrimination in the use of diagnosis and compulsory powers, mainly against people from Black African and Caribbean backgrounds. Amongst many other arguments, they also emphasised that the introduction of CTOs would be disproportionately used against certain ethnic minority groups (Daw, 2007). While they were able to lobby for a small number of changes, including statutory advocacy for those detained under the Act and some safeguards for the use of ECT, the majority of their key concerns were not taken on by the Government. The Alliance criticised the Government's final 2007 amendments to the MHA, describing it as a missed "historic opportunity to achieve a modern and humane act" (Dyer, 2007).

1.6.4 Call for reform in 2018 - Racial Disparities and the Use of the Mental Health Act

The MHA arguably enables some of the most coercive powers that can be enacted by the state. For instance, the MHA is one of the few pieces of legislation, outside of anti-terrorism legislation, that allows pre-emptive detention of a person without a trial or evidence of a committed crime (Pilgrim, 2007). Detention is solely determined upon professional judgement of who is deemed to be a risk to themselves or others. Unsurprisingly, mental health legislation has been subject to a number of critiques and continuous debates highlighting the need to protect and improve civil liberties and rights for people diagnosed with mental health disorders. At present, the current MHA in England and Wales only meets 54.2% of human rights standards set by the World Health Organisation (WHO) (Kelly, 2016). These standards provide detailed statements for human rights issues that need to be addressed in national legislation (Kelly, 2016).

Since the creation of the MHA in 1959, the legislation has undergone numerous reviews and reforms. Gostin (1983) argues that 'there is perhaps no other body of law which has undergone as many fundamental changes in approach and philosophy as mental health law' (p. 48). The need for constant reform is underlined by Hallsworth (2011), who notes that the notion of policy reform does not occur in a vacuum and is driven by the need to respond to events. This is particularly true for mental health legislation as the pressure to reform is often influenced not only by the socio-political climates of each time period but also by changing societal and professional attitudes and constructions of mental illness, risk and treatment (Cummins, 2020b). The MHA is one of the few pieces of legislation where changes are based on developments in professional knowledge (e.g., frequent changes in classifications of mental disorders, the development of new treatments and service design) as well as differing pressure from advocacy group campaigns and inquiries (Cummins, 2020a). Harpur (2011) argues that the focus on classification, illness and difference in conceptualisations of mental health contribute to the promotion of separation, stigmatisation and prejudice which stem from a medical model which underpins contemporary mental health legislation. While there has been a rise in social movements and approaches, including a shift to allow more professionals such as clinical psychologists powers under the MHA through the responsible clinician role, the medical model continues to shape and dominant service structure, law, treatment and professional decision-making under the MHA (Oates et al., 2018). This perhaps highlights the constant tension between legalism and medicalism, which refers to the tensions between privileging legal principles with the prioritisation of professional decision making, throughout the history of the development of mental health legislation (Szmukler & Gostin, 2021). An understanding of both the historical and societal developments provides context for the current mental health legislation and an understanding of how key arguments and processes have triggered the need to reform.

Following the amended MHA in 2007, the application of the Act as a whole has been called into question, in particular issues surrounding the rise in detention rates, use of CTOs, police contact, human rights violations, and racial disparities. For over a decade, there has been a significant rise in voluntary and compulsory detention rates, for instance, the rates for civil detentions between the period of 1997 and 2016 have almost doubled (Keown et al., 2018). Rains et al. (2020) conclude that there is no linear explanation for the increase, instead, they suggest there is a combination of factors, including changes in legal approaches and a reduction in community care. A similar increase has been evidenced in the use of section 136 of the MHA, with numbers rising by 12% in England and Wales between 2018 and 2019 (Home Office, 2019b). Concerns have also been raised about the lack of conclusive evidence for CTOs. Burns et al. (2013) found no evidence that the use of CTOs reduces hospital readmission or reductions in length of hospital stay. Despite this, there are substantially higher numbers of people on CTOs than originally estimated by the Government prior to its introduction (Taylor, 2010).

One of the most significant issues is the disparate use of the MHA between ethnic groups. Data over the last two decades suggests that people from certain ethnic minority groups, predominantly those with Black African or Black Caribbean heritage, are more likely to be detained and re-admitted under the MHA (Gajwani et al., 2016; Priebe et al., 2009), subject to a CTO (Oduola et al., 2019), and have longer inpatient stays (Mohan et al., 2006). In a 2017/8 report, the CQC highlighted concerns surrounding the continual overrepresentation of people from Black and Minority Ethnic (BME) backgrounds who were detained under the MHA. National data by NHS Digital revealed that detention rates were four times higher for people who identified as Black or Black British, with 321.7 per 100,000 of the population for Black/Black British people detained, in comparison to 73.4 per 100,000 for White British people (NHS Digital, 2021). A meta-analysis by Barnett et al. (2019) found that Black African and Caribbean patients, and to a lesser extent South Asian patients, were significantly more likely to receive a compulsory admission to hospital than patients within the White ethnic group. They also found that Black Caribbean groups were also more likely to be re-admitted to hospital in comparison to White ethnic groups. This evidence was consistent with previous findings over the past few decades, which have demonstrated consistent ethnic disparities with involuntary detentions, even after diagnosis and social factors have been considered (McKenzie & Bhui, 2007). Since the expansion of compulsory powers within the community, people from Black African and Caribbean backgrounds have also been disproportionately subject to the use of CTOs and are nine times more likely to be under a CTO than people from white British backgrounds (Oduola et al., 2019). Black African, Caribbean, and Asian Pakistani groups are also amongst the highest groups to receive a CTO recall (Campbell et al., 2019; Evans et al., 2010; Gajwani et al., 2016).

The impact of being detained under the MHA has also been called to attention. First-person patient accounts have also revealed concerns that dignity, autonomy and human rights are overlooked for those subject to the Act (Mental Health Alliance, 2017). Further issues have been raised by people from various ethnic minority backgrounds, particularly, reports of racism and stereotyping (Gilburt et al., 2008; Wagstaff et al., 2018).

In response to concerns, in 2017 the UK Government appointed an independent advisory panel, led by a psychiatrist, Professor Simon Wessely, to conduct an independent review of the MHA. The review looked at three main areas: the rising rates of detention under the MHA; the disproportionate number of people from Black and minority ethnic groups detained under the MHA; and processes which are “out of step with a modern mental health care system” (Department of Health and Social Care, 2017). The review was the first of its kind to aim to highlight racial and ethnic disparities as one of the terms of reference for consultation (Department of Health and Social Care, 2019).

The process of reviewing the Mental Health Act involved consultations with a number working groups appointed and chaired by members of the advisory panel. The working groups provided expertise on issues such as, service user and carer experiences, racial disparities, and academic evidence. Additionally, the advisory panel submitted a formal call for evidence, inviting public stakeholders to submit formal written evidence on a range of issues and topics pertaining to the terms of reference provided. Over 150 organisations submitted formal written evidence, with some stakeholders also submitting oral evidence during meetings and workshops on behalf of their organisation. A timeline of the process has been collated from information provided by the Department of Health and Social Care (2018a) (see Appendix C); however dates, time periods, and the outcomes of each of these key stages is not publicly available.

1.7 Rationale

The opening chapter has sought to demonstrate how racial inequities exist within the mental health system. Explanations for disparities are complex and multifaceted. Some research outlines how inequities are upheld and underlined by historical and societal injustices that operate in the mental health system in a number of overt and covert ways. This is particularly evident in the application of MHA, where the last few decades have evidenced consistent disproportionate use of a number of tenets of the MHA on people from ethnic minority backgrounds. There has been a recognition in wider legislation and policy attempts to address racial inequities and injustices in society as a whole. While throughout history there have been attempts to reform mental health care and legislation, recent attempts highlight the need to address issues of racial disparity in the use of the MHA, an area which has been historically neglected. As evidenced within the limited policy attempts to address racial disparities in the past, the material consequences for people from ethnic minority backgrounds remain. Past evidence has referred to how levels of racism in society and structures are often not included in attempts by policymakers to understand or tackle racial inequity (Nazroo et al., 2020).

There is a dearth of research investigating what occurs within the policy making process when racial disparities are being addressed and how or why this contributes to the failure to improve the material conditions of people from ethnic minority groups. In response to this niche in the evidence base, this present research study aims to explore stakeholders’ experiences of the consultation process in the 2018 MHA review; with a specific examination of how race was addressed throughout the process.

1.8 Research question

1. What influenced stakeholders in the consultation of the 2018 MHA review - in particular how they addressed race?

2. METHOD

2.1 Chapter Overview

This chapter outlines the steps and approaches used in the current research study. This chapter will begin by describing the epistemological position considered for the present study, followed by an outline of the methodological approach; procedure; method of recruitment; data collection and analysis used. Finally, a justification for conducting a thematic analysis (Braun & Clarke, 2006) within a critical realist epistemological position for this research is presented.

2.1.1 Research Focus and Question

The aim of the present study was to explore stakeholders' experiences of engaging with the consultation process for the 2018 MHA review and the extent to which racial and ethnic disparities were addressed. To the best of the researcher's knowledge, this study presented the first of its kind. For this reason, the researcher argued that adopting a qualitative methodology was justified in order to gain insight and understanding into the consultation experience.

2.2 Epistemology - Critical Realism

Epistemology refers to the nature of knowledge, specifically what is perceived as legitimate and meaningful knowledge (Carson et al., 2001). Epistemological positions can vary from the belief that the 'truth' can be uncovered, to whether one singular absolute truth is possible, with truth being based on perspective (Braun & Clarke, 2013). Saunders et al. (2009) highlight that identifying the position in which we believe knowledge derives from and how it is measured is essential for the researcher as it influences the methods and methodology employed that are parallel with positioning.

A critical realist epistemology holds the position that the way we understand the world is based on how we construct or make sense of our reality (Maxwell, 2012). The concept of critical realism was pioneered by Roy Bhaskar (Bhaskar, 1978, 2010), who proposed critical realism as a philosophy posited between realism and relativism. His development of critical realism challenged popular beliefs of positivism, specifically the notion that data can be gathered objectively (Harper & Thompson, 2012). He argued, instead, that the world is complex due to the interaction of numerous casual and structural powers (Bhaskar, 1978, 2010).

The philosophy of critical realism is arguably grounded in three key principles: ontological realism; epistemological relativism; and judgemental rationality (Al-Amoudi & Latsis, 2017). Critical realism is particularly concerned with ontology, the nature of reality (Fletcher, 2017). In contrast to other epistemological positions, such as a 'naive' realist position which assumes there is an unproblematically uncoverable 'truth' (Braun & Clarke, 2013), a critical realist position acknowledges that there are underlying structures and mechanisms within the 'real world' that impact social arrangements and understanding (Fletcher, 2017). Ontological realism acknowledges that underlying structures underpin individual experiences and perspectives, but also notes that individuals may not always be aware or easily access these structures in their observations (Smith & Ceusters, 2010).

The notion of ontological realism is important in the present study as there are many historical, political, social and structural factors that influence individual and organisational debates about the MHA (Al-Amoudi & Latsis, 2017). The contextual nature of knowledge is also acknowledged in the concept of epistemological relativism (Seidel, 2014). This tenet of critical realism recognises that knowledge is socially produced and imperfect. Epistemic relativism acknowledges that methods of data collection are fallible and whilst 'data' collected may not directly mirror the 'real' world, it can inform us about aspects of reality and observable experiences (Seidel, 2014). As a result, the notion of judgemental rationality highlights the need for researchers to consider their findings in a broader context in order to understand the factors that influence experiences and make connections between 'observed events and those mechanisms that cause them to happen' (Al-Amoudi & Latsis, 2017).

A critical realist epistemology has been chosen for this research as it acknowledges the structural reality of racism, whilst recognising that policy-making to address racism within mental health practices is a process where race, racism and mental health practices are experienced, constructed and understood differently by key stakeholders. This is also reflected in the processes involved in consultation.

2.3 Procedure

2.3.1 Developing an Interview Schedule

A semi-structured interview schedule (Appendix D) was developed based on the research question and following consultation with psychologists knowledgeable about the consultation process for the previous and current review of the MHA. The interview schedule was divided into three sections, with questions pertaining to three processes: i) pre-submission, ii) submission, iii) post-submission, totalling nine open-ended questions and prompts. The first section involved exploring participants' roles within their organisations and the strategy their organisations employed to prepare the submission. This included exploring who was involved and consulted in early discussions; how group membership was decided; areas of focus; decision-making about addressing racial disparities; and how decisions were made about what was included or excluded in written submissions. The second section explored any activities that were carried out in addition to the submission and reasons why. The final section explored stakeholders' views of the final report produced by the advisory panel and their feedback on the process. Following ethical approval, a pilot interview was conducted with two trainee clinical psychologists at the University of East London (UEL) to assess the suitability and clarity of the interview questions. Following the pilot interviews, feedback was obtained and small amendments were made to re-word questions to improve clarity.

2.3.2 Participants

Participants were recruited using a non-random purposive sampling method. This method involves deliberately selecting participants with experiences of a specific event/issue relevant to the research question (Jawale, 2012). In December 2018, a list of organisations that responded to the independent advisory panel's call for evidence was published on the UK government's website (Department of Health and Social Care, 2018b). The researcher screened the list and organisations which met the inclusion criteria were contacted by email or sent a message through LinkedIn. The email (Appendix E) consisted of information about the study, including eligibility and confidentiality. An information sheet was also attached to the emails (Appendix F). An email was sent directly to each organisation with a request for the person who lead the verbal and written submissions to participate. For the majority of organisations, this was the policy lead. Further details about the inclusion and exclusion criteria for individuals from organisations are detailed below.

2.3.2.1 Inclusion and Exclusion Criteria

The following inclusion criteria were applied:

- Participants had submitted written or verbal evidence as part of or on behalf of an organisation
- Participants played a key role in the written or verbal submission process on behalf of their organisation
- Participants were part of a mental health organisation, charity, professional body or non-governmental organisation

The following exclusion criteria were applied:

- Participants who were part of a public health body
- Participants with organisations focused on children or young people
- Participants part of organisations whose primary focus was not mental health or detention

2.3.3 Rationale for Sample Size

The sample sizes in qualitative research methods are often considerably smaller than in quantitative studies. This is because qualitative research methods are often focused on a more concentrated sample and are concerned with gaining a deeper understanding of a phenomenon (Braun & Clarke, 2013). However, selecting the appropriate sample size is often unclear and dependent on research aims and methodological considerations. Vasileiou et al. (2018) argue that data saturation is one of the key elements to consider when determining sample size. Data saturation is a concept predominantly used in GT research and is described as occurring when, the 'data collection process no longer offers any new or relevant data' (Dworkin, 2012, p. 1319). Dworkin (2012) notes that data saturation is based on a number of factors often beyond the researcher's control. These factors can range from selection criteria to determining the key conceptual and demographic stratifiers that are fundamental to investigating the topic area. Due to the specificity of the MHA review process, the sample size was largely governed by inclusion criteria and the need to ensure a variety of stakeholder views were given the opportunity to participate.

2.3.4 Sample

A total of 72 organisations were publicly listed on the UK Government's website, and of the 72 organisations, 13 met the inclusion criteria. Each organisation varied in employee and membership size and areas of focus. Emails and messages were sent to the corresponding person/s of 13 organisations and eight agreed to participate. The sample was comprised of five women, and three men. Six participants were from a White ethnic background and two were from a Black or Asian ethnic minority group. Participants were recruited from a range of organisations including professional bodies, charities and a working group. A summary of the selected participants' demographic information can be seen in Table 1. In order to protect anonymity, the specific ethnic background and age of each participant has not been included in the table.

Table 1.

Demographics of the study sample

Participant	Gender Identity	Organisation type
Participant 1	Male	Think Tank/Social Policy Group
Participant 2	Female	Charity/User Organisation
Participant 3	Female	Charitable Trust
Participant 4	Female	Charity
Participant 5	Female	Professional Body
Participant 6	Male	Working Group
Participant 7	Female	Professional Body
Participant 8	Female	Union and Professional Body

2.3.5 Interviews

Due to the COVID-19 pandemic, in-person interviews were discontinued and face-to-face appointments were requested to be conducted virtually through a number of remote video-conferencing platforms including Microsoft Teams, Zoom and Skype. Prior to participating in interviews, participants were informed that their interviews would be recorded and transcribed and informed consent was obtained. Interviews were conducted following a semi-structured interview schedule based on the research questions. At the end of each interview, participants were verbally debriefed and provided an opportunity to ask questions or discuss their participation. Interviews lasted between 45-120 minutes, with an average time of 60 minutes.

2.4 Ethical Considerations

2.4.1 Ethical approval

Ethical approval was obtained from the UEL's School of Psychology Research and Ethics Committee (Appendix G). The research study was conducted in accordance with the British Psychological Society's (BPS) Code of Human Research Ethics (British Psychological Society, 2014).

2.4.2 Informed Consent

Participants were provided with an information sheet outlining details about the purpose of the research study, which noted why they were asked to participate; what their participation involved; how confidentiality and data protection would be maintained and their right to withdraw from the research process. Participants were also provided with information on how to contact the researcher and research supervisor if they had any further questions or concerns regarding their participation or any aspect of the research. Consideration was taken to ensure consent was a continual process. Participants initially agreed to participate via email, and consent was confirmed at the start of the interview through verbal or written consent (Appendix H). Each participant was informed about their right to withdraw and remove their data without explanation, disadvantage or consequence, within two weeks of the interview.

2.4.3 Confidentiality

Consideration was taken to ensure that all participants' details remained anonymous in line with the Data Protection Act 2018. Audio-recordings made on a Dictaphone were immediately transferred to a password-protected computer after the interview had concluded, and then immediately deleted from the Dictaphone. All identifiable information in the transcripts was immediately anonymised or removed. Participants were advised that in the case of publication or further work derived from the present study data, any identifiable information would remain anonymised. The only names included in transcripts were those of the Government assigned advisory panel members due to this information being available in the public domain.

In order to further protect anonymity, participants were advised that only general descriptions of their organisations would be outlined, and pseudonyms would be provided. Further identifiable information, such as gender, age and ethnicity, were grouped and reported in broad categories.

2.4.4 Potential Distress

Although no distress was anticipated for the present study, an awareness of the political and racial nature of the topic was considered. There was an understanding that some participants may have professional and personal experiences of the MHA or racial discrimination. Additionally, discussions about racial inequality by those with and without lived experience can cause discomfort (Bell et al., 2009). As a result, consideration was taken when designing the questions to ensure the focus was predominantly based on the process of consulting. Additionally, participants were mainly asked to recall information retrospectively and comment on their experience of the process within the context of an organisation and not on any personal experiences preceding the consultation process. This process was taken to ensure participants had sufficient time to process the events leading up to the submission. Furthermore, in line with the BPS (2014) ethical guidelines, participants were debriefed after each interview and were provided with an opportunity to raise any questions or queries.

2.5 Rationale for Analytic Approach

Qualitative research refers both to the methods of collecting and analysing data, as well as a framework for conducting research (Austin & Sutton, 2014). It aims to answer questions by understanding experiences, meaning, and perspectives (Fossey et al., 2002). A qualitative approach uses words as 'data' and seeks to interpret and draw meaning from data collected within contexts (Braun & Clarke, 2013). Although quantifiable data can usefully indicate mental health outcomes or racial disparities, they may provide limited information on contextualised experiences (Macur, 2013) like the dynamics within the policy consultation and decision-making process, specifically, the diverse experiences of individuals situated within groups/organisations throughout the Mental Health Act consultation process. As a result, qualitative methodology enables a deeper understanding of how and why decisions are made (Choy, 2014). For these reasons, it was determined that a qualitative methodology would be most appropriate for the present research study.

Several qualitative approaches were considered to analyse the results of the present study. According to Coolican (2017), there are three main approaches to analysing semi-structured interviews: Interpretive Phenomenological Analysis (IPA) (Smith, 2004), Grounded Theory (GT) (Glaser & Strauss, 2017) and Thematic Analysis (TA) (Braun & Clarke, 2006). The justification for the use of TA for this research is outlined below.

IPA is a qualitative analysis approach that focuses on providing detailed examinations of common phenomenological lived experiences, concentrating on how the essence of a lived phenomenon is described and how individuals perceive and discuss their experiences (Smith et al., 2009). IPA tends to focus on smaller, concentrated samples where people have experienced a similar phenomenon. Due to the attention to language and meaning-making of a shared event in a concentrated sample, IPA was initially considered as a methodological approach to analyse the data from the present study. However, as an approach, IPA would involve a detailed exploration into each stakeholder's personal experiences of the MHA review process, rather than attempt to produce an overview of the process while attending to the socio-political context (Smith & Shinebourne, 2012). Braun and Clarke (2020a) highlight that a thematic analysis may better meet the needs of the study when the analytic interest is based on how personal experiences are situated within wider social-cultural contexts. Additionally, IPA typically requires a sample size of between three and six participants (Smith et al., 2009) and the present study had a sample of eight.

Grounded Theory was also considered as an analytic approach due to the dearth of research using this method to explore stakeholders’ experiences of policy and legislative consultation processes. A strength of GT is the emphasis placed on grounding the theory in the data and not within a pre-existing theoretical approach (Glaser & Strauss, 2017). As such, GT is often used to generate new theories or explanatory models (Glaser et al., 1968). This approach is helpful when there is limited knowledge of a particular phenomenon. A constructivist approach to GT was initially considered due to the acknowledgement that social processes are influenced by social contexts (Mills et al., 2006). However, a fundamental aspect of GT is the development of a theoretical model. Given the likely complexity of the consultation process, it was considered that a more exploratory approach to identifying key themes would be more suitable than an approach which aims to develop a model. The researcher hopes that these themes could inform future studies which might then lead to the development of a model of policy consultation.

2.5.1 Thematic Analysis

Studies have indicated that thematic analysis (TA) is one of the most used techniques in analysing qualitative data (Bell et al., 2018). TA enables the researcher to organise, analyse, and report themes (Braun & Clarke, 2006). In contrast to other methods, TA can be utilised within a range of theoretical and epistemological frameworks (Braun & Clarke, 2019). Historically, TA has been subject to criticism regarding the lack of rigour in its approach (Javadi & Zarea, 2016) however, a particular strength of TA lies in its flexibility. TA has often been described as theoretically flexible, and as an approach, it takes on the theoretical and philosophical assumptions of a particular study (Braun & Clarke, 2019). Due to its flexibility, Levitt and colleagues (2017) highlight the importance of coherence and explicitness in theoretical assumptions, particularly how research questions and design reflect the researchers' approaches to inquiry.

As an approach, TA addresses questions about experiences, meaning and multiple perspectives. Due to the lack of research exploring civil society's experiences of legislative consultation processes and the exploratory nature of the current research, TA was determined to be the most appropriate data analysis method which would enable the researcher to explore a broader range of viewpoints from key stakeholders and identify patterns across the dataset as opposed to focusing on individual experiences and characteristics.

2.6 Data Analysis

2.6.1 Transcription

Braun and Clarke (2006) highlight that the transcription process plays a key role in thematic analysis, as it is the first step where data familiarisation takes place and initial ideas about the data are developed. For the present study, interviews were transcribed verbatim, meaning that transcriptions were as close to speech and utterances as possible. Non-verbal communication was not included in the transcript as the aim was to focus on participant's verbal responses in relation to their experiences of the review process.

2.6.2 Analysis

A thematic analysis was conducted to analyse the data. Braun and Clarke's (2006) six-step guidelines were followed: familiarity with data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report.

The initial stage of data analysis began during the transcription process. Transcripts were repeatedly read in an active way to gain familiarity with participant accounts and also to generate initial thoughts and ideas. Before a formal coding process was conducted, any initial thoughts and process notes were written down underneath each line in italics. The next stage involved generating initial codes using line-by-line analysis using an inductive approach. Each code involved sections and elements of the data which provided interest or meaning to the author in relation to the research phenomenon (Nowell et al., 2017). Fereday and Muir-Cochrane (2006) note that codes can be theory or data-driven. Researcher driven codes are often referred to as 'latent' codes, where an existing conceptual and theoretical framework underpin implicit meaning making. In contrast, data-driven or 'semantic' codes refer to data coded based on the data's explicit content. The analysis was mainly data-driven. Although codes were largely derived from the data, they were also influenced by an awareness of related literature. All extracts were coded systematically in NVivo, with some extracts coded multiple times. Codes were then transferred onto a table in Microsoft Word. An example of a coded transcript can be found in Appendix I and J.

Consideration was made for how different codes may relate to another. Through an iterative process, the codes were then collated and organised into potential themes. Tables and mind-maps were used to review patterns within the data and provide a visual representation of each theme and identified codes. This stage involved examining the relationship between codes, themes and sub-themes. Codes and themes were also re-examined to assess whether they formed overarching themes or sub-themes within them. An initial thematic map was then created (Appendix K).

Using Patton’s (2014) dual criteria for deciding categories; themes were revised based on their internal homogeneity and external heterogeneity. This initially involved a process of reviewing the coherence of the data extracts within the theme, specifically whether the theme needed to be reworked or some data extracts needed to be moved or discarded. The second half of the process entailed reviewing the validity of each theme in relation to the data set as a whole. Following this process, a final thematic map was developed. Braun and Clarke (2006) note that the process of reviewing themes may occur multiple times and can be essentially 'infinite'. They acknowledge that it is challenging to provide clear guidelines on when to stop. However, they advise to stop the process of refinement when no substantial changes are being made.

In the final stages of data analysis, themes were refined, defined and named. This involved identifying the crux of each theme and ascertaining which part of the data each theme reflected. This stage required reverting back to each extract to ensure internal consistency and adding a narrative to describe the theme. Additionally, each theme went through an analytic procedure that involved identifying analytic interpretations of each theme in relation to the data, as a whole and the research questions. An evaluation of the quality of analysis can be found in the critical review section of the discussion chapter.

2.7 Reflexivity and Positionality

Reflexivity is considered an essential part of qualitative research (Dodgson, 2019). Bourke (2014) proposes that both the researcher's and participants' identities and positionality influence the process. Through a reflexive process, researchers are encouraged to make clear how their values, experiences and potential biases may influence the research process and how results are represented. Namely, how their identities such as class, gender and race intersect and motivate their reasons for conducting research (Jacobson & Mustafa, 2019). Bourke (2014) suggests that the development of self-reflexivity helps to serve as a 'checkpoint' to enable the researcher to question their approach to research.

The researcher's own identity, specifically in research that is political in nature and investigates disparities experienced by minority groups, has invariably influenced how the research was carried out, interpreted and analysed.

2.7.1 Personal Reflexivity

The reality of the disparities faced predominantly by people with Black African or Black Caribbean heritage within the UK relates not only to my identity as British-African but also as a trainee clinical psychologist practising within the mental health system. As someone who is described and racialised as an 'ethnic minority' within the UK and the clinical psychology profession, I am acutely aware of the UK's history of racism, which is also evident in present society. Unsurprisingly, the mental health system is not exempt or unique in perpetuating the exclusion and discrimination that people from racialised minority communities experience in wider society. It is important to note that a small part of this thesis was conducted in 2020 following the murder of George Floyd, an unarmed Black man who was killed by a White police officer (Brown et al., 2022). The news and context of his death have led to increased racial tensions in addition to foregrounding of discussions about racism and harm caused by state institutions. This has perhaps led to an increased societal discourse and recognition of structural racism (Brown et al., 2022). While only one participant was interviewed following his death, it is critical to recognise that George Floyd's murder may have covertly impacted their reflections during the interview. Similarly, if all participants were interviewed following his death this may have also perhaps led to differential or deeper reflections and discourses about the consultation process.

I am aware that discussions around race are often challenging for those who hold 'dominant' racial identities in the UK (i.e., White) and may be an emotive and difficult area of discussion for those from minority ethnic backgrounds. For the former, I was aware of how this discomfort may be exacerbated further for participants from a White ethnic background when being interviewed by a researcher from a Black African ethnic background. Although the questions asked about racial disparities were directly based on one of the terms of reference, I was still conscious of how this may have impacted how some stakeholders discussed their organisation's decisions and their positionality on the need to address racial inequity. This is in addition to my own awareness of how I received the responses. Throughout the interview procedure, supervision and peer discussions were utilised to facilitate personal and epistemological reflections. Reflexivity in relation to the analysis of the data is revisited in the discussion chapter.

3. ANALYSIS

This chapter presents an account of the key themes and subthemes identified through a thematic analysis of interview data. Each theme highlights the pertinent aspects of participants' experiences of the MHA consultation process and provides an insight into the underlying processes that shaped submissions. Three themes and nine subthemes were generated during the analysis and are presented in Table 2.

Table 2

Themes and subthemes

Main Theme	Subthemes
3.1: “It’s a charade”: Power and influence in the review process	3.1.1: “It was coming very much from his own discussions with individuals”: Influence of informal networks 3.1.2: Not based on evidence 3.13: Not listened to 3.1.4: “I think there was maybe like one BAME person in the room” 3.1.5: Does the real power lie elsewhere?
3.2: “This is how the political system works”: Power enacted in the design of the review	3.2.1: Assumptive framework 3.2.2: “People doing independent reports are never independent”: Political constraints 3.2.3: “It was all in a hurry” 3.2.4: “We had to do this with very limited time and under pressure”: Limited resources
3.3: Elements in an ideal consultation	

3.1 Theme One: ‘It's a charade’: Power and influence in the review process

Theme one explores participants' views on the review process as superficial, specifically, how power and influence in the consultation process both underlie the extent to which change can be achieved in the MHA reform. In subtheme one, participants discussed how having social and ideological proximity to the advisory panel commanded more influence. Whilst, in subtheme two, participants questioned the quality of evidence collected and presented in the final report. Participants reflected on whether recommendations made represented wider views or whether they reproduced the dominant medical discourses. The third, fourth and fifth subthemes explore notions of power within and beyond the review process. In the third and fourth subtheme, participants described how their concerns were silenced or ignored, whilst in the fifth subtheme, stakeholders' power to make change was questioned.

3.1.1 Subtheme One: 'It was coming very much from his own discussions with individuals': Influence of informal networks

In this subtheme, some participants described how social and ideological proximity to the advisory panel appeared to be as influential, if not more, than the written submissions.

Some participants felt advisory panel members were more reliant upon personal discussions within their informal networks. Many believed that the power and ability to influence lay with those within these networks.

> "'I know how these reports are done. Because the lobbying, you know, trying to get the ear of the person reading is very important. And in this I think, my impression was that [Chair of the advisory panel] was not really looking to submissions, he was looking to his own... it was coming very much from his own discussions with individuals." (Participant 1)

Participant 1 described how building a personal relationship through lobbying or belonging to the advisory panel's close social network was potentially more influential than written submissions. He felt that the advisory panel relied more on these conversations to inform the report. There is a suggestion that this process is perhaps a common occurrence within legislative consultation procedures and not unique to the MHA review.

The impact of personal discussions is reiterated by Participant 3. She, however, provides a positive framing from the perspective of being part of the advisory panel's informal network and how this enabled her organisation to share issues directly.

> “Before the meeting, I had a very fruitful discussion with [Chair of the advisory panel] and a number of the review team, which was a really good opportunity, I think to really talk through, you know, some of what you are asking me [in this research interview].” (Participant 3)

In addition to social proximity, the notion of ideological proximity was also explored by participants. Some felt that the medical model was a dominant approach throughout the process. There was also an implication that the advisory panel’s informal network shared an ideology that was more medical in focus and therefore organisations who ascribed to a medicalised approach were more likely to have their recommendations taken on.

> “'It seemed a bit as if the people who have had the most influence in the review were people who leaned more towards the medical model themselves, whereas the people who didn't, didn't really get a voice. So we did have our concerns” (Participant 2)

Concerns were also shared about the Chair’s professional background and the influence this would have on the direction of the report.

> “We'd always been concerned that there was a psychiatrist, as the chair of the review, because it seemed then very likely that there'll be quite a strong drive along the lines of a medical model. I mean, obviously there are some psychiatrists who are different, but [Chair of the advisory panel] is very well-known for, you know, his strong adherence to a medical model and his conviction, you know, that it's the right model. So, we were always concerned that was the leadership of the review” (Participant 2)

The absence of neutrality appeared to be a point of contention, both in terms of how participants viewed the government's position and their own judgements about the direction of the review. There is a suggestion that the choice of the chair was significant and implied particular governmental agendas. In particular, how these prior decisions by the government begin to shape participants’ perceptions throughout the process and act as indicators for them to draw early conclusions about direction and seriousness of review.

3.1.2 Subtheme Two: Not based on evidence

This subtheme notes participants' concerns about the quality of the evidence collected and presented in the final report. Some participants questioned how the evidence was selected and the decisions behind some of the recommendations made. In relation to the wider theme, the questioning of 'the quality of evidence' in this subtheme also emphasises participants' concerns about how power was exercised through a lack of transparency. Issues were raised regarding the prioritisation of some evidence over others. Many participants also questioned the extent to which the review was underpinned by quality evidence.

Participants shared their concerns about the quality and validity of evidence collected throughout the consultation process, specifically relating to the findings shared in the interim and final report.

> "We had a lot of concerns about shortfalls in the methodology, the data collection, data analysis, generally…We were very concerned about the quality of evidence in the interim report. For example, we knew from further figures we've managed to get, that there are actually only 537 responses to the survey that came from people with lived experience, which is a very small sample. And it's not made clear, when the figures are given or how many survey replies there were, that actually only 537 of them came from people with lived experience." (Participant 2)

Participants spoke to issues about the transparency of the data collection procedure — especially the lack of involvement of many service users and the subsuming of their responses amongst the responses of others.

Issues were also raised concerning the selectivity of pre-existing evidence and literature and how evidence was used or ignored. Participants spoke to how a conservative approach underpinned final recommendations despite examples of opposing evidence.

> "It was a perfect opportunity to do something that was really revolutionary, … one of the psychiatrists, [Name Removed], wrote an enormous piece of work and did a very good study around community treatment orders, and … why they are absolutely ineffectual. And this review was supposed to take those away, and I do not know why that didn't happen. I think it's a great shame. I think it's more than a great shame. I

> think it was it's really very poor indeed, that something that is such a flimsy evidence base." (Participant 8)

The discord between the evidence base and final recommendations further illustrates participants' questions about the implicit ideologies of the review. Insight is also provided about participants' hopes and expectations for the review. For example, for Participant 8 and others, this involved removing CTOs.

The failure to follow through on the need for radical change perhaps speaks to participants' sense of the review as a lost opportunity.

> "We're still not looking at our data and saying to society, you realise that this data is telling us some really powerful things, and we need to really change that. And to me, it's an offence. I find it deeply offensive." (Participant 6)

Participants further interrogated the common view that policy is developed by dispassionately weighing up the evidence and arguments. They regarded this as naïve and implied a more political process that certain groups and networks shape.

> "There are some people, but I would regard them as naive, who think that you win... you succeed in making changes in the policy area by presenting good data and good argument, and that's just bollocks" (Participant 7)

3.1.3 Subtheme Three: Are we being listened to?

In subtheme three, participants spoke to experiences of not being listened to when raising concerns about the processes and evidence behind suggestions made by the advisory panel.

Participant 2 highlighted how her organisation's written concerns had to be raised numerous times and early on, in the hopes that these would be addressed before the final report.

> "The first letter drew on what was happening at the time with the interim reports and looked at what the interim report was showing up in terms of the review direction. And the second one was written just before the final report was due for review, again,

> in hopes that we might influence the final review because we so far had just not really felt our concerns had been addressed at all" (Participant 2)

There were further concerns that the advisory panel remained unresponsive to a range of concerns, particularly from those questioning and critiquing the process.

Participant 1 also spoke to feelings of disappointment due to feeling silenced when raising issues and the content discussed in consultation meetings organised by the advisory panel.

> "But it was a really disappointing meeting. I mean, there wasn't anything in it. And I didn't ever, I wasn't given any chance to say anything. I wasn't called on to say anything. I was cut short." (Participant 1)

3.1.4 Subtheme Four: "I think there was maybe like one BAME person in the room"

In this subtheme, participants spoke of the exclusion of vital voices and discussions of issues addressing racism. One aspect of this exclusion involved the lack of representation and meaningful involvement of people from ethnic minority backgrounds. Many participants also talked about how racism was discussed within their organisations and in wider consultation with the advisory panel. Some touched on how racism was not seen as a forefront issue for their organisation. Instead, professional agendas or addressing the uses of the MHA as a whole were more pressing.

Many participants raised concerns about how comprehensively the advisory panel sought to consult with people from ethnic minority backgrounds, specifically those with lived experience of navigating the mental health system.

Participant 2 described that the final report appeared to focus on ethnic minority communities on a superficial level.

> "And I think on the face of it, the review report does show a lot of focus on BME communities. Our concern remained that they hadn't got all the data they needed to represent those views adequately. Another concern was that the particular framework that they were putting forward, I couldn't get any feedback as to what evidence was

> behind that. I mean, you probably know that initiative after initiative to gain greater justice for people from BME communities have just failed." (Participant 2)

However, from her own experience of the consultation process, she felt that not enough people from ethnic minority backgrounds were consulted to sufficiently represent their views. She also questioned the evidence behind recommendations and the positional framework the review adopted in relation to tacking racial disparities, especially as past initiatives in reducing racial inequality within the mental health system have failed.

Participant 1 also questioned whether people from ethnic minority communities were adequately consulted and whether this was possible due to the current climate. He highlighted that there is a lack of ethnic minority organisations, and out of the few that exist many of them lacked sufficient resources to sufficiently consult on a review at this level. He concludes that reviews cannot occur in a vacuum and raises the need for properly funded organisations which can contribute.

> "And they, you know, it's charade, you know, it's a charade, when they do consultations, they say we consulted BME organisation, there aren't, there virtually aren't any organisations who have proper resources to actually provide informed response to a report, to do a request like that." (Participant 1)

When asked if racial disproportionality was addressed in their submission as it was one of the three main topic areas of the review, many stakeholders noted that it was either excluded or not included as a central issue.

Participant 7 highlighted that he and his organisation felt that the key issues were mainly due to the application of the MHA and although this disproportionately affected people from certain ethnic minority backgrounds, it was not focussed on in their written submission.

> "Because of issues to do with the application of the Mental Health Act. They do disproportionately fall on people from the BAME community and we didn't systematically look at that.' - (Participant 7)

Participant 5 also acknowledged in response that racial disproportionality was not a big focus area:

> “I think our submission probably didn't have the biggest focus.” (Participant 5)

Participant 4, in particular, described how although there were discussions within their organisation about racial disparities, these discussions were not included in their final submission.

> “I don't think it was, it did as much in our actual… in our actual submission. But more so in the, in the conversations that I had with the team.” (Participant 4)

Although participants touched on the lack of representation from ethnic minority groups during consultations, the impact of the lack of ethnic minority representation by those leading the submissions within organisations was only raised by one participant.

Participant 7 discussed how not being from a 'Black' background ultimately meant that his attention would be diverted towards focusing on the MHA as a whole rather than on specific racial inequality issues.

> “And, you know, not coming from a black background myself, my tendency is to veer towards.. make recommendations such making the act is as good as possible, an act that applies to the whole body of the citizenship rather than make specific protections for people from black and minority ethnic backgrounds.” (Participant 7)

Participants who raised concerns about racial disparities discussed the implications of the lack of adequate consultation and honest discussions about racism.

> “I said, well, I don't know what this meeting is about. But I said, I hope that the elephant in the room in these sorts of meetings are at the table. And everyone went very silent. No one said anything. I think I then said the elephant in the room is racism. People were very embarrassed and didn't want to sort of take this up, but we then went on with the meeting.” (Participant 1)

Participant 6 reflected on how there was a need to advocate more for the impact of institutional racism and how current processes are underpinned by historical racism. He felt, however, that stakeholders within his group were limited in the extent they could address these issues.

> "I think I would have liked for us to have advocated more vociferously on matters of institutional forms of racism. So for me, how the kind of whole processes that we're using are built on kind of racist history and platform and to kind of do work on helping people is to see that and understand that. And we were limited in scope so it couldn't" (Participant 6)

Participant 1 also shared his disappointment that the consultations and the report did not address problems arising from racism.

> "The final report was pretty hopeless, useless…Because there was nothing in it. That would deal with fundamental issues that arise from racism." (Participant 1)

3.1.5 Subtheme Five: Does the real power lie elsewhere?

In this subtheme, participants questioned whether it was possible to make change within a policy or legislative space or if more meaningful change could be made elsewhere. Many participants alluded to the importance of doing work outside of the consultation/review processes to create change.

Participant 1 commented on his perception of consultation processes as performative and a tick box exercise to show work has been done on a surface level.

> "The consultations don't, most of the consultations are for show. To show that they've consulted, but they don't take consultation seriously. I don't think." (Participant 1)

In contrast, Participant 3 felt consultations held some value. However, she noted that the power to make a real influence may happen elsewhere. She did not see the submission having the same level of power for her organisation as engagement work with communities.

> "I think written submissions have value but it's not the same as being in continuing or dynamic kind of engagement work." (Participant 3)

Participants also noted how the review was only one element and how real change could be made regardless in other areas. Many provided broader insight into how civil society organisations try to enact change.

Participant 2, in particular, highlighted how engagement work with practitioners, commissioners and voluntary groups would continue regardless of whether her organisation's recommendations were taken on. She noted how one way to incite change involved engaging with stakeholders with different positions of power and providing them with an alternative framework.

> "Whatever happens with the review, we really want to get the CRPD [Convention on the Rights of Persons with Disabilities] on the agenda, you know, politically among practitioners, among commissioners, among voluntary groups… So unless you, you know, you start by making people very aware there actually is another model, you're not even going to begin to get change." (Participant 2)

3.2 Theme Two: "This is how the political system works": Power enacted in the design of the review

In theme two, participants highlighted how they felt the structural design of the review limited their ability to influence its outcome. In contrast to theme one, where participants outlined different types of enacted power, this theme focuses on processes by which their influence was limited. Participants spoke about how the consultation process designed by those in power invariably shaped the outcome. They mainly focused on how limited resources and political constraints made it difficult for many organisations and stakeholders to make meaningful contributions.

Theme two comprised of four subthemes. The first subtheme highlighted participants perceptions of a pre-existing assumptive framework that shaped their level of engagement and expectations. In the second subtheme, participants questioned the impartiality of the independent advisory panel and how political demands restricted them. While, in subtheme three, participants described how the timeframe and the construction of the review limited their ability to contribute. Finally, in subtheme four, participants discussed how limited material resources prevented them from consulting in an impactful and meaningful way.

3.2.1 Subtheme One: The assumptive framework of the review

In this subtheme, participants highlighted how factors throughout the consultation process, for example how the review was set up and conducted, led them to assume that a pre-existing framework was already guiding the review. They expressed how this ultimately shaped their consultation approach.

Participants spoke of their early realisations about the possibilities and limitations of the review. They implied that their organisations made pragmatic decisions early on to try and engage with the review in the limited framework provided, despite feeling that this would be insufficient and a fundamental reform was needed.

Participant 3 reflected on how the timeframe given by the Government shaped her organisation's view that the advisory panel only wanted recommendations. This led the organisation to deviate from its initial consultation approach to change the Act as a whole.

> "I suppose that is one reason why we thought it was okay to go with the approach of making recommendations that would amend the Act rather than reform, by creating a whole new Act, which was something we would have properly wanted, but that's not something you can do in the year." (Participant 3)

Participant 6 furthered the idea that stakeholders and organisations would always have to change their expectations or approaches to fit within the Government's or advisory panel's conceptual tramlines. There is a suggestion about the control and power the Government and advisory panel hold. Consequently, the review will always be limited to favour their approach, meaning radical reform is unlikely.

> "I contributed, because I thought it was a useful thing to contribute to, but I didn't really expect radical change, because you can't get that, you know. If your parents are saying, let's move around the rooms in the house, it's unlikely that they're going to do that and put themselves in the box room. You can move around and your siblings might get moved around and they decide who's going in the box room, but the head of

> the house doesn't put themselves in the box room. And I never expect policy makers and politicians to then shrink that power base. That's not how it happens." (Participant 6)

Participant 1 also highlighted how underlying narratives about the ability to address racism held by the advisory panel indicated early on the extent to which racism and racial disparities would be conceptualised and addressed.

> "What he [Chair of the advisory panel] kept saying was that there was, he recognised that there was racism, but there was nothing legally that can be done to beat racism. These are sort of arguments I've heard before was that racism is really about people's attitudes and you can't change attitudes through legal means and so legal changes can't make much difference, any difference. That was his starting point." (Participant 1)

3.2.2 Subtheme Two: 'People doing independent reports are never independent': Political constraints

This subtheme speaks to participants' views on the pressures and expectations placed on the advisory panel, specifically, their ability to remain independent of Governmental agendas. Some participants questioned how the political climate and political pressure shaped the consultation process and the final report. In connection with the overall theme, some participants expressed how the lack of neutrality of the advisory panel limited the extent to which the MHA could be reviewed, while others questioned how pressing the review was on the political agenda.

Participant 1 commented on the independent advisory panel's lack of impartiality due to the review being conducted within the context of a political system.

> "If he wanted to, if he [Chair of the advisory panel] really wanted to put in things about counteracting racism in the mental health system. He could have done it. I think, if he was, you know, independent. But he might have got into serious trouble in some way. This is how the political system works. In this, in most countries I suppose. So you're not independent. People doing independent reports are never independent." (Participant 1)

Participant 1 particularly highlighted how political pressure limited how the advisory panel addressed racism in the mental health system. There is an implication that perhaps radical change would be difficult and subject to consequences. A further suggestion is made that as political systems choose the advisory panel members, there will always be a conflict of interest. As a result, issues such as racism can only be adequately addressed if an advisory panel is truly independent of the government.

Some participants also questioned whether the review of the MHA was of significant importance on the government's political agenda.

> "But we are conscious that a lot of their, like there has been a little bit of drive lost on it, there are so many reasons for that. Some of its like political change some of its coronavirus" (Participant 5)

They specifically questioned its importance for the government in relation to other competing political demands, such as change within the ruling party and the coronavirus pandemic.

3.2.3 Subtheme Three: 'It was all in a hurry'

In subtheme three, participants critique the timeframe and organisation of the consultation process. Many participants shared concerns about the time allocated and whether an adequate consultation process was possible. Additionally, some participants questioned whether rushing the consultation process served as an underlying function to limit their contributions. Whilst others critically compared the 2018 process to the thoroughness of previous years.

Participant 1 and 2 commented on the lack of organisation of the review and the relaxed approach taken by the advisory panel.

> "I got the impression that it wasn't really not a proper review, because it's sort of review light as it were, they were just taking it in a very laissez faire way wasn't clearly organising it properly." (Participant 1)

> "Remember, this was all incredibly rushed" (Participant 2)

Participant 5 acknowledged the review was not perfect due to the timeline. However she felt the panel was as thorough as possible given the time restraints.

> "We were always very conscious throughout that there had obviously been quite a tight timeline that had been put on by the government. So I think we felt that the work of the review within the time given was pretty thorough. It maybe wasn't, I'm sure it wasn't perfect but within the sort of time given they were able to sort of cover a lot of ground." (Participant 5)

Participant 7 also noted the 'ad-hoc' nature of the review process, specifically in comparison to previous reviews of the MHA.

> "This time around 2018, the whole thing was a little bit more ad-hoc" (Participant 7)

Participants spoke to the consequences of how rushing the review process impacted their ability to consult.

> "It was all in a hurry, because, you know. [Chair of the advisory panel] said it had to be in by a certain date. In fact, he said the date was passed. So you know, we had to rush it. And it was, you know, wasn't mainly his fault, he was only given a, given a very short time to get what was really a very big job done." (Participant 1)

Participant 1 explained how organisations were asked to submit work after the deadline, meaning work was rushed by stakeholders. However, there was an acknowledgement of the competing demands and pressure on the advisory panel to complete a large task.

3.2.4 Subtheme Four: 'We had to do this with very limited time and under pressure': Limited resources

This subtheme highlights how limited resources given to organisations impacted how they could consult. Participants spoke to the complexities and limits placed on many civil society organisations without the added pressure of consulting. Many commented on how the lack of funding restricted what organisations and stakeholders could do. The financial pressure on smaller organisations, in particular, was acknowledged.

Participant 1 described how organisations were restricted due to a lack of financial resources to conduct their internal reviews in an ideal way — this limited who they consulted and who could contribute to their submission. There was perhaps an implication that organisations felt the advisory panel should have taken on this wider consultation work due to being well-resourced.

> “We didn't organise it, you know, if we had the resources, we would have organised a proper sort of series of meetings, with people, which is what I thought [Chair of the advisory panel] should be doing, but he wasn't doing that.” (Participant 1)

Participants explained how time pressures meant that they did not have enough time to put a range of views together in their written submissions.

Participant 5 discussed how one of the consequences of having time pressures meant that the focus was primarily on members' views within the organisation.

> “But probably I think at the written stage it was quite, you know we had quite a short amount of time to put together the written submission so we were quite focused on getting our members' views” (Participant 5)

Participant 4 spoke to how having more resources would have enabled a more comprehensive submission and would mean that more stakeholders would have been consulted. She highlights how charities, in particular, have limited resources and constantly struggle with deciding how best to use them.

> “I think we if we'd had the resources we could have, we could have done perhaps a slightly more in-depth submission involving more, more of our stakeholders, but I think that's one of the challenges for charities is, you know, how best to utilise your resources.” (Participant 4)

Participants also touched upon the idea that organisations did their best even with little to no resources.

Participant 4 also commented on the need to remain hopeful that their submission made some impact despite the pressure placed on organisations to produce a submission within a limited time frame.

> “So you know, actually considering you know, we had to do this with very limited time and under pressure, I felt that it actually had some impact. I hope it had some impact.” (Participant 4)

Participant 2 described how organisations did the best with the little resources they had but acknowledged that funding would have been beneficial.

> “I think we did the very best we possibly could in the circumstances, but it would have been so good to have had a lot more money” (Participant 2)

Participants commented on the financial implications of not being paid to consult or put together a submission. Participant 7 spoke about how more time spent on the reviews means hours away from paid work. He raised concerns about how competing demands and lack of funding for stakeholders to consult meant work was not conducted as adequately as they would have liked.

> “We're not paid for doing it either. If I were to spend 100 hours working up a discussion paper on mental health reform, for the [organisation name removed], you know, that's months of my life, where I'm not working for my employer… And I suppose I mean, there's all sorts of ways of feeling guilty, like, could have put in more effort, could have stepped up the plate and actually, you know, developed designs” (Participant 7)

Some participants described feelings of guilt, knowing they could have done more. However, they acknowledged that these feelings were mediated by the knowledge that their efforts were limited by the resources given, both in terms of finance and time.

3.3 Theme Three: Elements in an ideal consultation

In theme three, participants spoke about the elements they felt would have been beneficial in an ideal consultation. Participants' views were broadly split into two categories, the first involved aspects of the process leading up to their organisation's written submissions and the advisory panel's final report that they would have liked to have changed. The second involved differences on a structural level and focused on how they would have liked the review conducted and actioned by the independent advisory panel.

From an organisational perspective, participants referred to the need for their organisations to consult more people. They specifically highlighted a desire to involve more people with lived experience of mental health and their carers.

> "I kind of feel it might have been nice to have a broader range of people's voices from a lived experience perspective" (Participant 6)

> "We should have got people with lived experience of and carers, because they, we would have had better examples for the review of where [job role removed] could play a really pivotal role in helping people understand their rights" (Participant 8)

Participant 8 felt that if they had included the views of people with lived experience and their carers, it would have highlighted the fundamental role some healthcare professionals play in supporting people to understand their rights. While Participant 6 noted that in order to gain a lived experience perspective organisations would need to draw from a broader range of people.

Participants also reflected on how in hindsight, they would have liked to develop a more strategic approach and construct their organisational consultations in a way that would make it more accessible for people who would usually find it difficult to comment. Finally, they touched on the consequence of how not doing this meant that they missed out on a lot of expertise.

> "Whereas, you know, in an ideal world, you know, I probably would have done a lot more contacting to make sure that people perhaps [who] were not finding it quite so easy to make immediate comments, one way or another definitely were." (Participant 2)

> "I mean you still need a good strategy for reaching people who might not engage with that kind of process. So maybe we need to be very strong on proactively seeking this range of people, we might have missed out on a lot of expertise. You know, it's one thing to set people up for experiences, but lots of people with those experiences will have a lot of views as well, and reviews and good ideas. And whether they make the most of that I don't know" (Participant 3)

Participants also reflected on how impactful it would have been to facilitate a way for the advisory panel to hear directly from families beyond the written submission.

> "I think, for them to have heard directly from those most affected, but we weren't given the, the funds to do that. And it's quite, you know, it's quite resource intensive to set those things up in a meaningful way." (Participant 4)

Participant 4 highlighted the need for funding from the advisory panel for this to have been done in a meaningful way.

Participants also discussed the action they would have wanted from the independent advisory panel in an ideal review. They made reference to a need for a more systematic approach to reach more people, a diverse advisory panel and an accountability framework.

> "So if they had been more systematic, they would have got better representation from people affected by the legislation, and probably better input." (Participant 7)

Participant 7 commented on the need for the advisory panel to organise the review more systematically. He felt that this would allow an increased representation of people with lived experience and provide better contributions.

The desire for a more representative and diverse advisory panel was also touched upon.

> "If you think back to the review panel, was the two very vocal excellent members of the BAME community who represented both people from the service, carers and service users, but the majority, the other people on that panel, were all white. And I

> found that very, really, really challenging that they've chosen...But it was all right to ask the service users and carers to be representative of that diverse community, but not actually really the panel. So I think that was a mistake, they should have had a more cross cutting diverse group to be part of that review." (Participant 8)

Participant 8 shared the need to ensure that the advisory panel was subject to the same requirements given to service users. She felt that representation fell short when it came to the advisory panel and those in higher positions.

Participants felt the advisory panel and their actions needed to be held within an accountability framework, especially as many participants felt a lack of action or change following the advisory panel's final report.

Participant 4 suggests that reports and recommendations are ineffective if the contents are not implemented:

> "A report and its recommendations are, are only as good as their implementation." (Participant 4)

Participant 3 furthered this critique and shared the need for more dedicated immediate action and work towards more fundamental reforms:

> "I think we would have wanted to see more and more commitment to starting work now to do more fundamental reform in the future." (Participant 3)

Participants described how a monitoring process would ensure that the advisory panel's recommendations were held to account.

> "But I think whenever there's an independent review with recommendations about improving the experiences of people, what is really important is that there's regular monitoring as to what has happened to those recommendations" (Participant 4)

> "I would love to have had a system where there was a group that existed outside of the auspices of the review. In fact, it did kind of happen, where people were doing

> similar thinking and similar work. But we didn't have an accountability framework."
> (Participant 6)

They explained that for recommendations to effectively improve the experiences of individuals impacted, there needed to be a monitoring process or an accountability framework to ensure recommendations were adhered to.

3.4 Summary

This chapter has presented an analysis of the findings of eight semi-structured interviews with key stakeholders involved in the consultation process of the 2018 review of the MHA. Three main themes were identified; "It's a charade": Power and influence in the review process; "This is how the political system works": Power enacted in the design of the review; and Elements in an ideal consultation. Overall, the study revealed the multi-layered ways power operated within the review and consultation process. In particular, how structural and organisational processes inherently create barriers for policy actors. A critical view of the processes underlying the consultation was highlighted. This involved questions about bias and rigour of evidence collected and selected; and how adequately those from racialised minority backgrounds and people with lived experience were involved. Furthermore, there was an implication that those with limited informal connections and alternative views to the perceived dominant perspective experience more barriers when trying to enact change or question the advisory panel about the process. The analysis also highlights that the ability to enact change is also compounded by organisational limitations in time and resources, moreover that organisations who advocate for minoritised groups are further impacted. It was clear from the views of stakeholders that these power structures lead to a shift in organisational consultation strategies and perceptions about achievable change. This shift appears to be in contrast to pre-existing hopes for fundamental change. The analysis also suggests changes needed within stakeholders' respective organisations and Governmental consultation procedures in the future to adequately address inequities within the consultation process and in turn produce better recommendations to address racial inequities in the use of the MHA.

4. DISCUSSION

In this chapter, a summary of the main themes in relation to the broader literature and societal context will be presented. Both the strengths and limitations of the research will be explored in addition to implications for future research and practice. In the final section, the quality of the analysis will be examined, and a critical review of the research project will be offered.

4.1 Summary of Analyses

In summary, the research question explored 'What influenced stakeholders in the consultation of the 2018 MHA review, in particular in how they addressed race?'.
Each of the three main themes of the analyses, will be discussed subsequently.

4.1.1 Theme One: "It's A Charade": power and influence in the review process

Central notions about the ways in which power and influence were exercised to dominate and shape the review process were highlighted in this research. Participants spoke to the perceived preferential influence actors and organisations within the advisory panel's informal network held. They stressed how personal and social proximity afforded those within informal networks more access to the advisory panel, and opportunities for their organisations' views to be heard beyond the traditional avenues of formal consultation. Lewis (2006) comments on how policy actors with informal connections are often provided a level of connectedness and influence that is made possible through their social ties.

While the concept of ideological proximity holds similar benefits (Bratton & Rouse, 2011), the consequences for actors and organisations with ideologies dissimilar to the perceived dominant, medical approach was commented on by participants. Their experiences highlight the prevailing dominance of the medical approach and parallel similar findings in policy research where those who do not ascribe to a medical model report face more barriers when trying to present recovery-orientated reform (Byrne et al., 2016; Harpur, 2011). The benefits of proximal ideologies in policy-making are supported by literature investigating Homophily in policy, an approach which highlights how policymakers and legislators show preferences to those with ideological similarities (Currarini et al., 2016; McPherson et al., 2001).

The idea of policy review as a rational or fair process was questioned by participants throughout this research. Participants perceived there to be a lack of transparency in data collection methods and the use of written and oral forms of evidence. Thus, implying that recommendations in the final report were underlined by bias and misuse of the evidence submitted. Suggestions were made that the advisory panels not only had the power to selectively choose evidence but also to decide which evidence was seen as compelling. These findings are in line with a report by the Institute of Government, where civil servants within Governmental departments report having power and incentive to 'tone down' unfavourable findings (Hallsworth et al., 2011). Practices such as these exemplify arguments made by Critical Race Theorists about how Whiteness operates within legislative procedures to create and interpret 'evidence' and law in a way that inherently disadvantages racialised minorities (Ladson-Billings & Tate, 2016; Neely & Samura, 2011). As a consequence, issues of racial inequity are de-centered and depoliticised, therefore Governments may sanction solutions which are variations of past failed recommendations (Bhopal & Pitkin, 2020), also potentially reflecting Whiteness in Government practices. Furthermore, the evidence included in policy-making is used to favour and reify pre-existing Governmental agendas and continue a cycle of minimal change (Cairney & Oliver, 2017; Head, 2016). Hallsworth (2011) notes that there is a complicated history of evidence-use in Governmental policy-making, one that can never be extricated from its political dimensions.

The research findings suggest that selectivity and bias in the evidence use also impacted which policy actors were listened to. Two specific processes were commented on: firstly, the lack of responsiveness by the advisory panel when stakeholders raised concerns and; secondly, the silencing of specific stakeholders. Participants who commonly reported these dynamics belonged to underrepresented groups with protected characteristics.

While the Government noted the issue of disproportionality as one of the key areas of focus in the terms of reference, several participants commented that their organisations had limited to no discussions or recommendations relating to racism and racial inequity in their submissions. Belonging to a White ethnic group was attributed as a reason by those participants as to why they had tended not to focus on issues of racial discrimination. There was also a commonly-cited view, or assumptions, held by a number of White participants that addressing the Act as a whole would inadvertently address racial inequity and therefore it was not included (or seen as important to include) in their submissions or discussions as a separate issue. These findings emphasise how racialisation and Whiteness perhaps operated within the review, demonstrating the hierarchical value attached to who is seen as important, whose experiences of the Act and which issues are foregrounded, backgrounded or ignored. Racial inequity, and arguably, also racialised people subjected to the powers within the Act, are positioned as inferior and insignificant compared to more mainstream debates about the use of the Act. This is in spite of consistent evidence of racism and disproportionality (Barnett et al., 2019; Wagstaff et al., 2018). Carr (2015) argues that the inability to see and address racism as an important and separate issue illustrates how Whiteness operates in policy-making. He describes a process of 'overgeneralisation' where the over-focus on a dominant group's experiences is used to overshadow issues of racism, resulting in the downplaying of racial inequality. This notion is aligned with comments by a number of participants in this study and also speaks to the lack of descriptive and substantive representation of people from ethnic minority backgrounds and advocation for issues which impact them. Specifically, how the overwhelming representation and limited advocacy of policy actors from White ethnic groups reinforces a failure to address issues of racism within the mental health system (Ashe, 2021; Curry-Stevens et al., 2011; Nazroo et al., 2020).

The numerous ways in which people from ethnic minority backgrounds were excluded, either through limited consultation or perceived silencing, were also raised. The exclusion of voices embodies the racialisation of knowledge and value; where voices of White people and their ideas are seen as inherently more superior and significant and therefore, sought and listened to (Carmichael & Hamilton, 1967). Critiques were also raised about the claims made by the advisory panel that a wide range of ethnic minority service users and organisations were consulted. Some participants highlighted the link between years of austerity measures and the lack of ethnic minority organisations and policy actors represented. Many emphasised how organisations who provided spaces for ethnic minorities with lived experience or focused on addressing racial inequality had been underfunded and de-commissioned (Craig, 2011; Harries et al., 2020; Tilki et al., 2015). This underfunding is shown to not only impact on the number of organisations who could contribute to the consultation process but also on the years of social mobilisation and external work many other organisations rely on to enact change (Cummins, 2020b); demonstrating the multifaced impact of structural racism. Despite the claims, the lack of representation was perhaps recognised by the government, at least to some extent given the creation of the Mental Health Act review's African and Caribbean group 'MHARAC' during the review (Department of Health and Social Care, 2019).

The 'type' of ethnic minority representation was also raised by participants. Some shared concerns that the very small number of ethnic minority people in senior positions with authority were selected due to their views aligning with Governmental agendas or their unwillingness to criticise the Government – seen by participants as their desire to maintain their status and influence. This perhaps highlights a similar process within the 'Commission on Race and Ethnic Disparities' report where the Government was criticised for appointing an advisory panel of ethnic minority people who would pursue and select evidence to support the Governmental push back against anti-racist movements (Pilkington, 2021). This points further to the possibility that processes such as these within policy development explain why previous attempts to address racial and ethnic inequity at a policy level have failed (Ashe, 2021; RAWOrg, 2010).

The accumulation of the issues raised by participants emphasise the number of covert and overt ways power operated within the review. Participants implied that the disempowerment of those from ethnic minority backgrounds in the policy-making arena enabled those with positions of power and influence the means to shape how racism was conceptualised, if at all, and addressed within the policy space. Essentially, pointing to the ways in which racism is commonly reduced to personal interactions and how structural conceptualisations of racism are resisted, a process of racism highlighted by Nazroo et al. (2020). One powerful example of this, within the research, is in one participant's reflection that from the inception of the review, the advisory panel chair explicitly held and articulated an overarching view that racism cannot be addressed from a policy or legislative level. Using a Critical Race Theory frame, Bonilla-Silva (2015) argues that often White people who appear to develop an interest in racial equity end up using their position to preserve racial status quos. This is evident in how despite the purpose of the review, the findings illustrate that racism was still positioned as idealised and fundamentally exempt from legal protection; which is in direct contrast to other laws, such as the Equality Act and Human Rights Act, which acknowledge racism as part of social structures.

Due to the number of experiences noted above, there was an overarching sense that organisations had limited power and influence to make any changes through the legislative review process. Instead, suggestions were made regarding other areas where meaningful impact could occur; this was notably outside of the policy process. Participants spoke to more effective ways to make change; which included engagement work within their networks in line with their organisational agendas, meeting with stakeholders who hold different levels of power, organising at a community level, introducing alternative frameworks, advocating for non-legislative change on a service level and tackling public perceptions. To a degree these findings are supported by arguments that civil society organisations' main influence lies in their ability to change public perception, pressure Governments to trigger a reform or oppose policy recommendations (Cummins, 2020b; Fox, 2015; Toms, 2017).

4.1.2 Theme Two: "This is how the political system works": power enacted in the design of the review

Participants perceived the review as structurally designed in ways which limited their ability to consult meaningfully. There was an indication that Governmental decisions made prior and during the review both played a key role in shaping participants' ideas about their organisational approaches and the level of achievable impact.

The findings highlighted a process by which stakeholders' assumptions about the central framework guiding the review were marked by decisions and actions from the Government. For example, participants highlighted how the choice of the advisory panel chair, the narrow time-frame of the review process and the political climate and context in which this review was instigated, and its timing, influenced their perceptions and actions towards the review. The assumptive framework for many participants and their organisations, was that the review required modest revision rather than a fundamental rethinking of contentious tenets of the Act and its applications. In response, many adapted their approach to making small and less weighty suggestions rather than proposing significant steps towards a more radical reform. One important finding involved querying the neutrality of the advisory panel, particularly the appointment of a Chair who is known to be a proponent of the medical model in his approach. There was an implication that this decision was deliberate, and a political decision in line with the pre-existing agendas on reform, one that would impact the extent to which the Government would allow the Chair to critique or divest from Governmental manifestos/agendas. Commenting on the previous MHA reform, Peay (2000) supports some of the underlying assumptions made by participants and argues, that to some extent, advisory panels are not tasked to formulate policy, rather their role is to implicitly enable legislation to reflect Governmental policy agendas. The findings imply that stakeholders are not passive participants within policy processes, instead, they reveal how stakeholders make judgements and adjust their actions based upon the Government and advisory panel's actions and their perceived power or lack thereof.

The findings also highlighted how lack of material resources and time affected organisations' ability to consult; this is also widely reported in a number of previous studies (Murphy et al., 2021). The 2018 MHA review was posited against the timeframes in previous reforms. While previous reforms were reported as long arduous processes involving conflicting views between state and non-state policy actors, in some cases, they have arguably led to more fundamental changes (Hilton, 2007; Toms, 2017). There were some suggestions by participants that the limited timeframes perhaps served as a function to restrict consultations and limit the extent the Act could be reformed. Emphasis was placed on the specific implications this had for smaller organisations with limited pre-existing resource and no financial support by the advisory panel. As noted earlier, many of the organisations impacted by constraints in time and funding represent the needs of minoritised groups. This further speaks to how power operated within the review process and the implication that organisations with more resource are ones with views aligning to the current dominant approaches to mental health reform and are more likely to uphold status quo. The findings suggest resources are fundamental in order to mediate the power imbalance that prevents minoritised organisation's ability to present alternative frameworks and challenge dominant ones.

4.1.3 Theme Three: Elements in an ideal consultation

Retrospective accounts of an idealised consultation structure were highlighted in the findings. Participants described key elements and changes they believed would have improved the consultation process. These proposed changes apply to stakeholder organisations and also, more systemically, to the Government and the appointed advisory panel.

Several participants expanded on how increased timeframes and material resources noted in theme two would have enabled them to improve their level of social engagement and gather better internal evidence. They specified the need to not only speak to people with lived experiences of mental health but equally conduct their engagement approaches to reach those who are unlikely to be consulted or aware of consultations. In their view, a range of voices would strengthen their evidence pool and recommendations. This is particularly important as directly hearing first-hand testimonials from people with lived experience has been found to trigger policy-makers to conduct further research (Moreland-Russell et al., 2015); an area which many participants felt was lacking in the MHA due to limited resources. The importance of user and lived experience involvement has been echoed in previous research into public health policy, however, similar to the research findings, previous research has stressed the importance of attending to power imbalances to prevent tokenistic involvement (Ocloo & Matthews, 2016; Read & Maslin-Prothero, 2011).

The need for diverse racial representation was presented as a solution to forefront issues of racial disparities in a review process. Representation was positioned as a corrective to counteract power dynamics and allow policy actors from ethnic minority backgrounds to raise issues without feeling silenced. Speaking from a clinical psychology context, Patel (2010) argues that whilst representation brings voices of colour to the fore it only tackles one aspect of inequality. Furthermore, representation as a solution alone fails to interrogate and dismantle the ways in which Whiteness and Eurocentricity dominate research and practice (Patel, 2010), or the legislative processes in the leadership and construction of the review. Additionally, it fails to attend to how institutional racism operates outside of and within the review process and structurally impacts on representation, knowledge production and involvement (Fernando, 2017).

At a more structural level, the findings suggest a desire for advisory panels to have a more systematic and accountable approach to consultation. There was an implication that in the MHA review this should mirror the processes of engagement that individual organisations undertake, especially when organisations do not have the scope or resources to engage as widely. The need for an accountability framework was of particular importance, due to the lack of action or clarity by the Government outlining how recommendations were adhered to and would be implemented. Hallsworth et al. (2011) recognise that many existing policy practices fail to account for 'real world' dynamics and often depart from good practice during political pressure or crisis. They suggest the need for responsive external engagement, clarity on Governmental roles and accountabilities and mechanisms for feedback and evaluation to counteract this (Hallsworth et al., 2011). Many of these recommendations reflect issues raised by stakeholders regarding the shortcomings of the consultation process. Consequently, specific proposals were made by participants for an independent group to be positioned as external and independent to the advisory panel to engage in similar work and hold the Government to account during the policy process and implementation stages. This perhaps suggests an underlying distrust by stakeholders and highlights the need for an external independent body free from the political process. There was a clear need expressed, that regardless of the approach, transparency from the Government about decisions made and the review process was much needed.

4.2 Critical Evaluation

4.2.1 Implications

There are several recommendations arising from the analysis in this research. These recommendations focus on future policy-making, professional training and service development.

4.2.1.1 Policymaking and Legislative Reform

Several recommendations can be drawn from findings that relate to future policymaking and legislative reform processes. Specifically, the need for active steps to remove power dynamics and processes of racism within the consultation, policy creation and policy implementation. While the current research aimed to provide an exploratory examination of stakeholders' experiences, the reflections shared by participants provide contributions to good practice. The findings potentially provide the early stages of a framework to improve policy-making processes in the future; one aimed at addressing how institutional racism operates within our mental health systems and attempts to reach racial equity.

The experiences and recommendations of participants highlight broad areas for change applicable to the MHA reform process and other areas of policy. These areas include equity in involvement in the initiation and creation of mental health policy, structural awareness, increased access to resources, and accountability. While the MHA reform process aimed to seek consultation from external stakeholders, the findings implied that policy processes are often experienced as exploitative, extractive and silencing for those from minoritised groups, such as people with lived experience of mental health or people from racial and ethnic minority backgrounds. Glassman and Erdem (2014) describe top-down approaches, such as those commonly found in Governmental policy-making procedures, as an "oppressive relationship where researchers accumulate knowledge as 'wealth' and 'reputation' with no share or benefit accruing to the participants" (p. 215). In order to counteract processes of power, community and participatory frameworks may offer a shift to bottom-up approaches to policy-making. These approaches are grounded in frameworks that work alongside marginalised groups to facilitate systemic change and awareness of the social and structural processes that impact them (Montero et al., 2017). This includes a genuine ideological shift by those in positions of power and influence to frame distress and subjugation through the lived experience and social realities of those impacted. In relation to this research and wider racial disparities in mental health, this would mean situating disparities in mental health practices and outcomes within the sociohistorical contexts which uphold institutional racism in the mental health system, but also, in the inherent design of the policymaking which lends itself to favour those in power. As an alternative, community and participatory approaches avoid using extractive methods of consultation and prioritise the participation of marginalised groups in decision-making, this often ensures that ideas and areas for policy change are also initiated and led by communities affected (Taggart, 2018). Some participants alluded to employing bottom-up methods in their organisational processes. Perhaps policy-makers can draw from examples already implemented by many user-led civil society organisations.

In addition to applying bottom-up approaches as a way to frame issues within their structural context and remove the controls placed on channels of participation and debate, Nelson (2013) argues that improving policy processes would also involve transforming how resources are allocated. The research findings suggest that future policy-making and consultation processes need to ensure a redistribution of material resources and compensation for labour to enable individual stakeholders and organisations to have the capacity and means for involvement. Ideally, prioritising funding will prevent future stakeholders from experiencing the process as extractive and reduce consultation fatigue, a process whereby marginalised stakeholders are involved in multiple consultations with little funding or time and observe little change for their communities (Simpson & Clifton, 2014). The findings imply that funding and time provided for consultation need to occur before a policy process is initiated. Perhaps future policy-makers need to consider ongoing and sustained funding for organisations and professionals who represent the needs of marginalised groups. This can help to mediate the structural impact they experience outside the policy-making processes where they receive disproportionately lower levels of funding and research grants (Belluigi & Joseph, 2021; Harries et al., 2020). Consequently, this may reduce the prevalence of dominant discourses and political agendas.

Lastly, the findings imply a need for an accountability framework in future reforms of the MHA or general policy development, especially as past reforms and policy documents have failed to improve the material conditions for people from ethnic minority groups. While civil society organisations arguably play a role in social accountability, the need for more formal frameworks placed on Governments during and following policy developments has been suggested.

4.2.1.2 Professional Bodies, and Clinical Psychology Training

The role of clinical psychologists is continuously expanding. The most recent change has seen the profession widen its approach from a primary focus on intra-psychic interventions to include macro-level approaches, such as policy and service development (Browne et al., 2020). This is evident in the involvement of clinical psychologists in policy consultations and Governmental calls for evidence, such as MHA reforms (Harper, 2005) and consultations regarding the prescribing rights for psychologists (Aston et al., 2021). The need for clinical psychologists at all career stages to exhibit a number of leadership skills, such as promoting equality and diversity and influencing policies and organisational procedures, is consolidated in the 'Clinical Psychology Leadership Development Framework' developed by the BPS (Skinner et al., 2010). The shift to macro-level interventions, is perhaps, occurring at a time when there are wider calls to understand psychological distress in the context of social inequalities and attend to disparities in care through policy and legislation (World Health Organization, 2014). Despite this shift, clinical psychologists have reported a lack of training in public health development and policy involvement (Browne et al., 2020). This is in parallel due to longstanding concerns of racial inequity and prevailing Whiteness in clinical psychology training (Ahsan, 2020; Wood & Patel, 2017).

The findings in this study highlight a need for current and future stakeholders to be adequality trained in approaches to policy-making in order to attend to and minimise the social processes of power and racism within policy-making. This is of particular relevance to Clinical Psychologists as they play a key role in service development, work in teams where the Act is applied and can also hold powers under the Act through the 'Responsible Clinician' role. In line with the American Psychological Association's commitment to rectifying psychologists' role in upholding racism (American Psychological Association, 2021), the findings highlight the need for UK professional bodies to also equip staff with the skills and training to tackle disparities at a macro-level. In order for this to occur, psychologists need to be aware of the ways they uphold and maintain Whiteness both in micro and macro levels ways of intervening (Fernando, 2017). Nadirshaw (2019) emphasises the need to prevent imperialistic approaches to leadership, specifically colour-blind methods often exhibited in a one size fits all attempt which ignores diverse needs and fails to meet the needs of multi-cultural and multi-ethnic societies. This is particularly pertinent as professionals hold considerable power in policy-making and as highlighted by participants in this study, race is often subsumed under broader arguments, resulting in policy failing to meet the needs of those from racialised groups.

4.2.2 Methodological Challenges and Future Research

The study was based on the experiences of stakeholders during the 2018 review process until the final report was published by the advisory panel in September 2018. Participants were interviewed a year and a half later and asked to recall their experiences retrospectively. Although participants drew upon personal notes and written recordings of the consultation process during the research interviews, there are possible restrictions in participants' ability to thoroughly recall the process to the same ability as they would if the interviews were conducted immediately after the process (Shiffman et al., 1997).

While purposive sampling enabled this research to focus on stakeholders who submitted verbal or written consultations as part of an organisation, the research was not fully representative. As aforementioned only two of the participants belonged to ethnic minority groups and although participants from a White background also spoke to processes related to racial subjugation and power, the lived experience of being from a racialised minority perhaps could have been expanded on to include stakeholders who have advocated for issues pertaining to racial equity in previous reforms, despite those issues not overtly stated as the main focus for past reforms. Additionally, the method of data collection could have been expanded. The study was based on a qualitative approach focusing on one-to-one interviews. Incorporating other data collection methods may have allowed a broader understanding and produced more robust results. Perhaps including group interviews may have allowed a minority of participants who did not highlight experiences of subjugation an opportunity to reflect and expand on power dynamics in a way that was not attended to in individual interviews. Guest et al. (2013) highlight that there is no perfect way of conducting qualitative research and each approach allows for benefits and limitations depending on the qualitative inquiry. They do however note the benefits of using mixed methodological approaches to expand the richness of data collected (Guest et al., 2013).

The design and findings of this research can be expanded on to improve policy and legislative attempts which aim to achieve better racial equity. Firstly, future research could focus solely on the experiences of racialised minorities involved in policy-making, including those who are not able to consult or decide not to. Only a minority of participants involved in this research were from ethnic minority backgrounds, which is indicative of the lack of civil society groups able to represent the needs of racialised minorities. Perhaps conducting research with groups who chose not to consult or have consulted in the past can provide a rich insight into the consultation barriers. Secondly, further research could aim to track the outcomes of the consultation process by applying some of the recommendations from this study to review if breaking down some of the structural aspects of the policy-making impacts on policy implementation and improves the material conditions of ethnic minority groups within mental health services. This could provide richer information on good practices needed to reduce institutional racism within policy-making.

4.2.3 Assessment of Research Quality

Due to the many differences in methodological and epistemological considerations in qualitative research, Spencer and Ritchie (2012) suggest that a one size fits all, strict criteria for assessing research quality may not fit. Instead, they suggest three guiding principles that underpin concepts of quality, these involve contribution, credibility and rigour. Spencer and Ritchie's (2012) three guiding principles were considered when assessing the research quality of this study. This approach was chosen due to its flexibility in application to a range of epistemological and methodological positions. The guiding principles are also accompanied by a range of questions to consider when appraising the research, this reflexive approach felt well suited to the current research, mainly due to the use of a critical realist thematic analysis.

4.2.3.1 Contribution

Contribution refers to an appraisal of the value of the conducted research, to areas such as, theory, policy and practice (Spencer & Ritchie, 2012). Spencer and Ritchie (2012) describe how, in qualitative research, this requires an "in-depth and nuanced understanding of the way particular people in particular circumstances construct, talk about or experience their micro-social world" (p. 229). The findings of this study contribute to theoretical understandings of policy processes, as well as implications for clinical governance and practice. This is the first qualitative study to follow and investigate key stakeholders' experiences of engaging in a mental health legislative review. The study provides novel insights into many nuanced experiences of the processes occurring on a policy level as well as attending to vital concerns surrounding how racial disparities are addressed in the mental health system.

A research study of this nature calls for transparency within these processes and allows a rare insight into some of the processes which underlie final decisions made in policy reports. Although the study highlights a range of processes, it also suggests ways of moving forward by outlining the barriers and provides suggestions to structural and organisational changes that can make review processes more transparent, fairer and accessible. The novelty the research provides is the beginnings of understanding the resistance and barriers, particularly from the perspective of how race is navigated or circumvented, to making change at a policy level which invariably has immense impact on mental health practices, and on outcomes for racialised people within the mental health system. It provides some understanding to the reported discord in the literature between the clear evidence of disproportionality in the application of the MHA with those from racialised backgrounds and of structural racism and appropriate action (Nazroo et al., 2020; Younis, 2021).

4.2.3.2 Credibility

The concept of credibility refers not only to the defensibility or plausibility of findings but also to the clarity in understanding how conclusions are made. Spencer and Ritchie (2012) underlie that credibility is based on transparency in evidence presented, this includes clear evidence of descriptive accounts, interpretive and constructed accounts (e.g. diagrams) and raw data. For a thematic analysis this may respectively refer to initial codes, themes and subthemes, thematic maps and original transcripts.

To ensure credibility each step of the research process was well documented and followed a guiding framework for data collection and analysis (Braun and Clare, 2006; 2020). Verbatim quotations within the analysis section (see section 3), a transcribed and coded copy of the raw data (see Appendix I) and a thematic map highlighting the process of generating higher order groupings were used as 'evidence' to support the findings.

While plausibility was demonstrated within the discussion section, where the findings were critically examined in the context of existing and new literature. To further assess credibility, both the author's positionality and personal reflexivity were made transparent and also revisited (see section 2.7 and section 4.3).

4.2.3.3 Rigour

Spencer and Ritchie (2012) underline rigour as the processing of assessing the appropriateness behind research decisions and the conduct of research. In qualitative research, this often involves reflexivity and a consideration of the researcher's role and position to the research process. When assessing research quality for TA, Braun and Clarke (2020b) highlight the importance of the researcher 'owning' their perspectives and attending to both their personal viewpoints and social positioning. This was achieved through outlining clear research methods and steps, adhering to BPS code of ethics, a clear consideration of methodology and analysis used in reference to alternatives and a consideration and revisiting of personal reflexivity throughout the process.

4.3 Reflexivity Revisited

The research findings and research process have highlighted the importance of qualitative and epistemological approaches which enable participants to speak to their lived realities in parallel to social processes that occur. The dominance of power experienced by participants during the consultation process has reinforced my belief that we need to continue to shape our practice and policy processes to better meet the needs of the people we work with. Moreover, it has enabled me to reflect on the need to move away from understanding experiences through only a positivist framework. Upon reflection using a qualitative approach was particularly powerful in this study as it provided participants the space to reflect and speak on their own perceived realities regardless of their social position. Throughout this research I have been acutely aware of how processes found in the study mirror processes which occur within research and clinical practice, where White Western knowledge and perspectives are often prioritised. This, perhaps, is not limited to how this research study will be observed and judged.

At each stage of the research, I have been reminded of the multiple positions I hold as a researcher, psychologist and also a British Black-African woman. While my role as a researcher has enabled me to take an ‘outsider’ role, hearing from people who hold a similar racialised identity as myself remains a constant reminder of the restrictions placed on people based solely on the social positions they occupy. Interestingly, interviews with participants from ethnic minority backgrounds were considerably longer than interviews with White participants. This perhaps speaks to a level of comfortability participants may have when sharing challenging experiences with a researcher also from an ethnic minority background. This may have enabled some participants to speak and reflect on their experiences of subjugation in a way that was denied to them within the consultation process.

The research process has also enabled me to reflect on the interaction between myself and participants from different ethnic backgrounds and how our different lived realities covertly impact the interview process. Perhaps, Pratt’s (1991) concept of ‘the contact zone’, the idea that social spaces where different cultures clash can allow individuals to grapple with different forms of racial power, is of particular importance for the present research as the research process has created a social space to foreground topics of racial inequity with participants from different racial backgrounds in the context of participating in a consultation process in a seemingly White space.

4.4 Conclusion

The research set out to explore the experiences of stakeholders involved in the verbal and written consultations for the 2018 MHA, with particular reference to how race was discussed. Overall, the research revealed the dominance of power dynamics within the review and the restrictions these placed on stakeholders' ability to consult and address issues of racism within the consultation process and as a key area within their recommendations. The operation of power was multi-faceted and layered. Ideological differences in addition to the lack of proximity to the advisory panel were highlighted as a key barrier to presenting approaches alternative to the dominant medical model. With regards to racism, participants emphasised and implied how processes of Whiteness dominated the review and shaped how racial inequities were conceptualised. These processes also led to the disempowerment of stakeholders from ethnic minority backgrounds. Systemic issues outside of the review were also raised, namely, the impact lack of funding had on smaller organisations and those representing minoritised groups, such as people with lived experience and people from ethnic minority backgrounds. Lastly, the findings present key areas of change both within individual stakeholder organisations and within the review process. The findings have implications for future stakeholders, particularly mental health professionals involved in policy development or consultation. Reference is made to the number of ways future policymakers can work towards a bottom-up approach to policy that situates ideological understanding through the lived reality of subjugated groups such as racialised minorities. This has implications for the way the policy process is constructed and also how issues of racism can be centered and addressed.

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Wilson, M. (2010). *Delivering race equality action plan: a five year review*. Department of Health. http://data.parliament.uk/DepositedPapers/Files/DEP2014-0975/PQ202552_PQ202500_-_Report.pdf

Wilson, M., Ramsden, S., & Clark, M. (2009). Delivering race equality in mental health in England: The importance of pathways. *International Review of Psychiatry, 21*(5), 427-429. https://doi.org/10.1080/09540260802211043

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology, 47*(3), 280-291. https://doi.org/https://doi.org/10.1177/0081246317722099

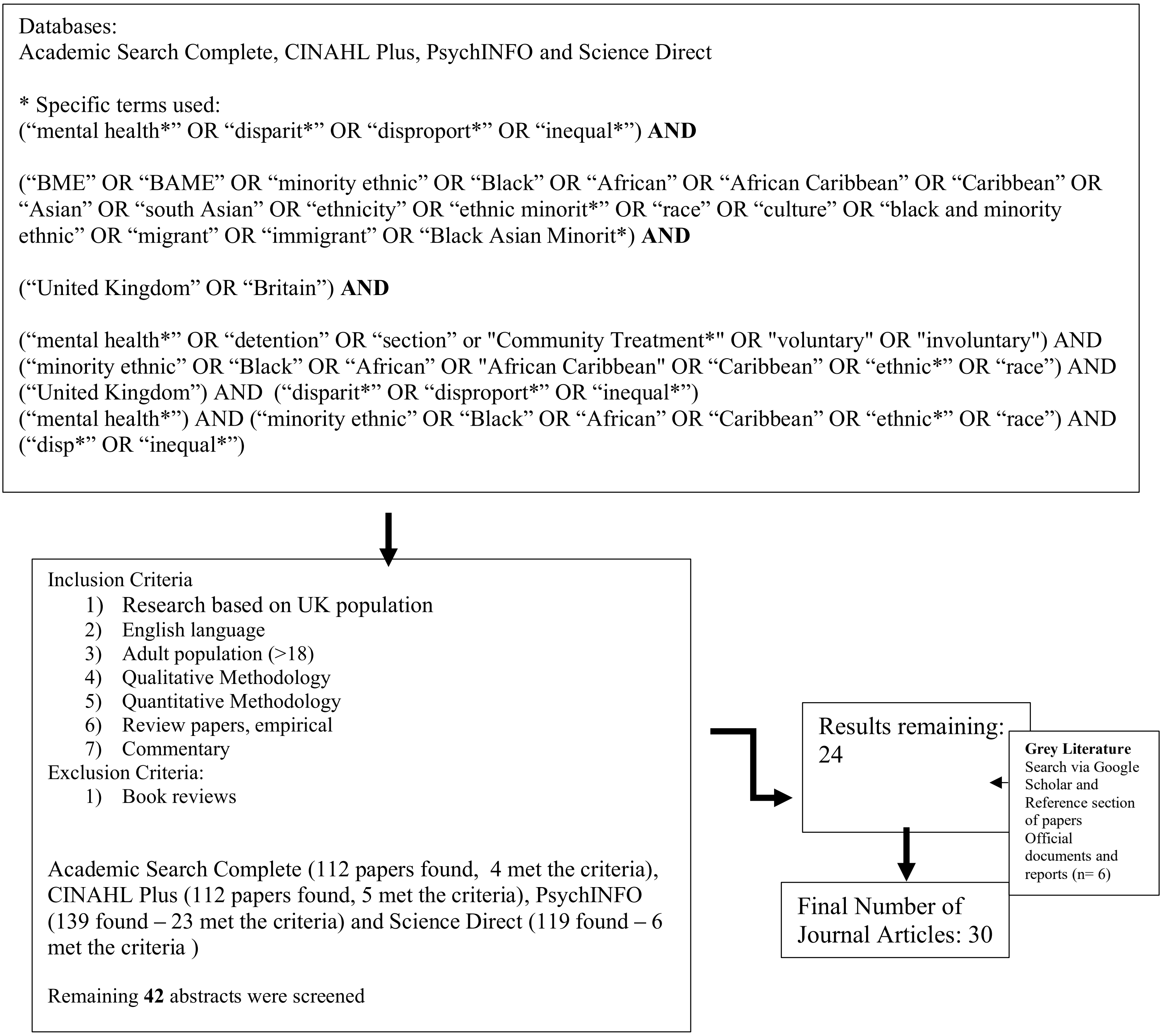
World Health Organization. (2014). *Social determinants of mental health*. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

Younis, T. (2021). The muddle of institutional racism in mental health. *Sociology of Health and Illness*, 1-9. https://doi.org/10.1111/1467-9566.13286

6. APPENDICES

Appendix A – Search Strategy

Narrative Review Database Search Strategy – Race and Mental Health in the UK



Databases:
Academic Search Complete, CINAHL Plus, PsychINFO and Science Direct

* Specific terms used:
(“mental health*” OR “disparit*” OR “disproport*” OR “inequal*”) **AND**

(“BME” OR “BAME” OR “minority ethnic” OR “Black” OR “African” OR “African Caribbean” OR “Caribbean” OR “Asian” OR “south Asian” OR “ethnicity” OR “ethnic minorit*” OR “race” OR “culture” OR “black and minority ethnic” OR “migrant” OR “immigrant” OR “Black Asian Minorit*) **AND**

(“United Kingdom” OR “Britain”) **AND**

(“mental health*” OR “detention” OR “section” or "Community Treatment*" OR "voluntary" OR "involuntary") AND (“minority ethnic” OR “Black” OR “African” OR "African Caribbean" OR “Caribbean” OR “ethnic*” OR “race”) AND (“United Kingdom”) AND (“disparit*” OR “disproport*” OR “inequal*”)
(“mental health*”) AND (“minority ethnic” OR “Black” OR “African” OR “Caribbean” OR “ethnic*” OR “race”) AND (“disp*” OR “inequal*”)

Inclusion Criteria
1) Research based on UK population
2) English language
3) Adult population (>18)
4) Qualitative Methodology
5) Quantitative Methodology
6) Review papers, empirical
7) Commentary

Exclusion Criteria:
1) Book reviews

Academic Search Complete (112 papers found, 4 met the criteria), CINAHL Plus (112 papers found, 5 met the criteria), PsychINFO (139 found – 23 met the criteria) and Science Direct (119 found – 6 met the criteria)

Remaining **42** abstracts were screened

Results remaining: 24

Grey Literature
Search via Google Scholar and Reference section of papers
Official documents and reports (n= 6)

Final Number of Journal Articles: 30

Appendix B - Literature Table

Author/Year	Aim	Literature type	Ethnic Group
Anand, A. S., & Cochrane, R. (2005). The mental health status of South Asian women in Britain: A review of the UK literature	To reports on the findings from epidemiological studies of the prevalence of depression, suicide, parasuicide, deliberate self-harm and eating disorders in the South Asian women community.	Literature review of studies	South Asian
Athwal, H., & Bourne, J. (2015). Dying for justice.	Report on patterns of deaths in police custody and state centres	Report	Black and minority ethnic groups
Bansal, N., Bhopal, R., Netto, G., Lyons, D., Steiner, M. F., & Sashidharan, S. P. (2014). Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: The Scottish health and ethnicity linkage study.	To investigate ethnic variations in psychiatric hospitalisations and compulsory treatment in relation to socioeconomic indicators in Scotland.	Quantitative - cohort study design	All ethnic groups included in comparison
Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner.	To investigate the cultural influences on symptom presentation and help-seeking and may influence the general practitioner's assessment	Quantitative	Punjabi ethnic group in comparison to ‘English’ group

Bhui, K., Ullrich, S., Kallis, C., & Coid, J. W. (2015). Criminal justice pathways to psychiatric care for psychosis.	To investigate whether violence explains criminal justice pathways (CJPs) for psychosis in general, and ethnic vulnerability to CJPs	Quantitative study - population-based survey	Comparisons across ethnic group. Emphasis on comparison between White ethnic group, Black Caribbean and Black African
Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health: Literature and evidence review.	Commissioned report to improve knowledge and understanding of good practice to enable better outcomes for black and minority ethnic (BME) communities who have a mental illness and experience of mental health treatment	Report	Black and minority ethnic communities
Bruce, M., & Smith, J. (2020). Length of stay among multi-ethnic psychiatric inpatients in the United Kingdom	To investigate the mechanisms that underlie the disproportionate rates of psychiatric admissions and length of stay among Black and minority ethnic groups.	Quantitative - quasi-experimental	All ethnic groups included in comparison
Cabinet Office. (2017). Race disparity audit: Summary findings from the ethnicity facts and figures website	To understand differences between ethnic groups, and identify those public services where work is needed to develop effective strategies to reduce racial disparities.	Governmental report	All ethnic groups included in comparison
Care Quality Commission. (2011). Count Me In 2010 Census.	National census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales	Report	All ethnic groups included in comparison
Commander, M., Cochrane, R., Sashidharan, S., Akilu, F., &	Comparison of pathways to psychiatric hospital and provision of inpatient care and after-care for minority ethnic groups	Mixed-methods	Asian, 'Black', and White

Wildsmith, E. (1999). Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, in-patient and after-care.			
Commander, M., Odell, S., Surtees, P., & Sashidharan, S. (2004). Care pathways for south Asian and white people with depressive and anxiety disorders in the community.	To understand mental health needs, use of alternative support and primary care treatment in South Asian people.	Mixed-methods	South Asian
Ghali, S., Fisher, H. L., Joyce, J., Major, B., Hobbs, L., Soni, S., Chisholm, B., Rahaman, N., Papada, P., & Lawrence, J. (2013). Ethnic variations in pathways into early intervention services for psychosis.	Examination of ethnic variations in duration of untreated psychosis and pathways into early intervention psychosis services.	Quantitative	All ethnic groups included in comparison
Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK.	To explore the processes which define service-user experience of hospitalisation since the introduction of community care.	Qualitative	White British, Black British and Asian British included
Independent Police Complaints Commission. (2010).	Examination of deaths in or following police custody	Report	All ethnic groups included in comparison

Deaths in or following police custody: An examination of the cases 1998/99-2008/09.			
Johnson, M., & Weich, S. (2010). Consultation, referral and ethnicity: the role of primary care in accessing mental health services.	Exploration and comparison of ethnic variations of early experiences of help-seeking for serious mental health difficulties	Qualitative	White and 'Black' ethnic groups
Joseph–Salisbury, R., Connelly, L., & Wangari-Jones, P. (2020). "The UK is not innocent": Black Lives Matter, policing and abolition in the UK.	Reflections on racial disparities in UK policing	Reflective review of high profile case studies	Black African and Caribbean case studies
Kapadia, D., Nazroo, J., & Tranmer, M. (2018). Ethnic differences in women's use of mental health services: Do social networks play a role? Findings from a national survey.	To examine ethnic differences of women's mental health service use in England	Quantitative	White British, White Irish, Black Caribbean, Bangladeshi, Indian and Pakistani
Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle?	To explore the content and consequences of fear which lead to poorer treatment experiences for people from Black African and Caribbean communities within mental health services	Qualitative study	Black Caribbean, Black African, White and Asian
Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016).	Exploration of perceived barriers to accessing mental health services among people from ethnic minority backgrounds	Qualitative study	'Black Minority Ethnic'

Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England.			
Mental Health Act Commission. (2009). Coercion and consent - Monitoring the Mental Health Act 2007–2009.	An overview of the care provided to people detained under the Mental Health Act	Governmental report	All ethnic groups included in comparison
Mercer, L., Evans, L. J., Turton, R., & Beck, A. (2019). Psychological therapy in secondary mental health care: Access and outcomes by ethnic group.	Explore ethnic differences in access to and outcomes of psychological therapy	Quantitative	All ethnic groups included in comparison
Morgan, C., Fearon, P., Lappin, J., Heslin, M., Donoghue, K., Lomas, B., Reininghaus, U., Onyejiaka, A., Croudace, T., & Jones, P. B. (2017). Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: the ÆSOP-10 study.	To explore ethnic differences in the course and outcome of psychiatric disorders.	Qualitative	White, Black African and Black Caribbean ethnic groups
Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between	Exploration into how research can better understand processes underpinning the differences in pathways to care between ethnic groups	Literature review	All ethnic groups included in comparison

social science and psychiatry.			
Newman, L., Harris, V., Evans, L. J., & Beck, A. (2018). Factors associated with length of stay in psychiatric inpatient services in London, UK	To identify factors associated with lengthy stays in psychiatric hospitals	Quantitative	All ethnic groups included in comparison
Payne-Gill, J., Whitfield, C., & Beck, A. (2021). The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings.	To investigate the relationship between ethnicity and use of restrictive practice	Quantitative	All ethnic groups included in comparison
Pinto, R., Ashworth, M., Seed, P., Rowlands, G., Schofield, P., & Jones, R. (2010). Differences in the primary care management of patients with psychosis from two ethnic groups: A population-based cross-sectional study	To examine ethnic differences in primary care management of patients diagnosed with psychosis.	Quantitative	All ethnic groups included in comparison
Prajapati, R., & Liebling, H. (2021). Accessing Mental Health Services: A Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK.	To examine the qualitative evidence on the experiences of British South Asian adults who access community mental health services.	Systematic literature review	British South Asians

Rabiee, F., & Smith, P. (2013). Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK	To explore the experiences of service use, service provisions from the perspectives of Black African, Black Caribbean mental health service users, carers, service providers and commissioners.	Qualitative	Black Caribbean, Black African, White British and Asians
Schofield, P., Das-Munshi, J., Mathur, R., Congdon, P., & Hull, S. (2016). Does depression diagnosis and antidepressant prescribing vary by location? Analysis of ethnic density associations using a large primary-care dataset.	To examine depression diagnosis and anti-depressant use for different ethnic groups at a neighbourhood level.	Quantitative	White British, Indian, Pakistani, Bangladeshi, Black Caribbean and Black African
Wagstaff, C., Graham, H., Farrell, D., Larkin, M., & Nettle, M. (2018). Experiences of mental health services for ‘black’men with schizophrenia and a history of disengagement: A qualitative study.	To examine the experiences of Black African and Black Caribbean men who have a schizophrenia diagnosis and a history of disengagement from services	Qualitative	Black African and Black Caribbean

Appendix C – Timeline of the 2018 Independent Review of the Mental Health Act

Key events (August 2017 until 14th September 2018, the publication of the final report)

1.	August 2017, Prime Minister Theresa May announces an independent review of the Mental Health Act. Three terms of references were outlined: 1.Rising detention rates, 2. Disproportionate number of Black and Minority Ethnics detained under the act 3. Stakeholder concerns that some processes relating to the act are out of step with a modern mental health system
2.	October, 2017 Theresa May announces Professor Simon Wessely will lead the independent review of the Mental Health Act with Vice chairs; Steven Gilbert, service user and serious mental health living consultant; Sir Mark Hedley, retired high court judge; Rabbi Baroness Julia Neuberger, former CEO of the King's Fund.
3.	Advisory panel created a formal call for evidence for stakeholders to consult on the terms of reference. Over 150 sector organisations and bodies responded to call and focused on a range of issues and topics. Stakeholders submitted written evidence. Some stakeholders also submitted verbal evidence through meetings and events.
4.	A working group is created by advisory panel to support the development for recommendations. Members are appointed due to their range of experience of the Mental Health Act and its application. The working group was chaired by Professor Simon Wessely.
5.	Service user and carer group created consisting of people who have been detained under the Mental Health Act or have experience of caring for an individual who has been detained. The group was chaired by vice-chair, Steve Gilbert and report directly to the chair, Professor Simon Wessely.
	Service user and carer survey circulates to learn about experiences of detention. Focus groups were delivered to discuss issues affecting various groups such as, people with learning disabilities, people from BAME communities. Workshops

	were also hosted in Cardiff, Newcastle and London with service user, carers and professionals in attendance.
6.	The African and Caribbean Group established to provide recommendations on the experiences and needs of people from African and Caribbean descent subject to the Mental Health Act. The group involved academics, medical professionals and race equality experts. The group was chaired by Jacqui Dyer and advisory panel vice chair, Steve Gilbert and report directly to Professor Simon Wessely.
7.	Evidence and Analysis working group created consisting of academic institutions, National Health Service Trusts and public sector services. The group was created to advise on evidence relating to the Mental Health Act with a focus on academic evidence. The group was chaired by Professor Simon Wessely.
8.	Interim report published on 1st May 2018
9.	Topic groups consisting of a small group of experts were created to explore the main issues set out in the interim report. Findings were submitted to the advisory panel on 14th September 2018.
10.	Final report published

Appendix D - Semi-Structured Interview Schedule

INTERVIEW SCHEDULE

Pre-submission

1. What was organisation that you represented?
    - o What was your contribution?

2. When you were getting together a group of people to draft the consultation how did you decide who to invite to this discussion?
    - o How was the membership decided?
    - o Which kinds of people/views were represented?

3. How did you and your organisation/group go about making decisions of what to say and what not to say?
    - o How was it drafted (e.g. one person, sections delegated, drafts for comment)?
    - o Any theoretical framework? What was guiding the decisions? Why?
    - o Were there other voices you would have liked to have included? Why?

4. Who wrote the draft and who commented?
    - o How did you decide what comments to pull together?
    - o What informed them (e.g. what ideas drawn on)?

5. One of the areas of focus of the review was to understand the disproportionate number of people from black and minority ethnic groups detained under the Act. In your consultation response, to what extent race considered discussed and included in the submission? Why?
    - o If yes – what said?
    - o If no, why was that? What was the thinking behind that (e.g. what focused on instead, why?)

Submission

6. Was there anything else that you or your organisation/group did, in addition to submitting the response? Why?

Post-submission

7. What are your views on the content of the final Wessely report?
    - o To what extent were your organisation's response was taken into account

8. Looking back what could have been differently by you and your organisation/group and why?

9. Is there anything that I haven't asked that I would like to add?

Appendix E - Recruitment Email

Dear Sir/Madam

I am currently a third year trainee clinical psychologist at the University of East London. For my doctoral thesis, I am interviewing people who have submitted written evidence, as part of an organisation, for the 2018 Mental Health Act review. The aim of the research is to explore the process of putting together written evidence and working as part of a group. I am also exploring the range of issues that each organisation chose to focus on. The project is supervised by Professor David Harper, with input by Professor Nimisha Patel.

I would appreciate it if you could circulate this email to everyone who was heavily involved during the process of submitting on behalf [Organisation], to see if they are able to participate. The research will involve confidential interviews via Zoom, Teams or Skype. Interviews will last up to one hour.

I have attached a copy of the information sheet below. Please do not hesitate to email me if there are any further questions.

Warm Regards,

Julie Baah

Trainee Clinical Psychologist
Doctoral Candidate
Professional Doctorate in Clinical Psychology
University of East London
Water Lane, London, E15 4LZ

Appendix F - Information Sheet

University of East London

Pioneering Futures Since 1898

Organisations' Contributions to the 2018 Review of the Mental Health Act

PARTICIPANT INFORMATION SHEET

I would like to invite you to take part in a research study. Before you agree it is important that you understand what it involves. Please take time to read the following information carefully.

Who am I?

I am a Trainee Clinical Psychologist in the School of Psychology at the University of East London. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

The study will explore the experiences and role of mental health practitioners who have contributed as part of an interest group to submit evidence for the 2018 Mental Health Act (MHA) review. The study will also explore the process of putting together written evidence and which issues were chosen as areas of focus and why.

Why have I been asked to participate?

You have been invited to take part as I am looking to interview mental health practitioners who were a part of an interest group or organisation which submitted written evidence for the 2018 Mental Health Independent Review.

What will taking part involve?

- Interviews will take place at the organisation you are part of or at the University of East London (UEL) with Julie Baah (Trainee Clinical Psychologist).
- Some interviews may be held over the telephone or online (e.g. if you work outside London)
- Interviews will last up to one hour

Will what I say remain confidential?

Your privacy and safety will be respected at all times:

- You will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research
- You do not have to answer all questions asked and can stop taking part at any time
- In the unlikely event that I am worried about your safety or others I will need to tell someone. Whenever possible I will let you know first that this is happening

What will happen to the information I provide?

- Only I will listen to recordings and transcribe (i.e. type up) your interviews.
- Any information you give which might identify you (e.g. names, places etc.) will be changed when I type up the interview (e.g. giving you a pseudonym)
- The typed transcript may be reviewed by my supervisor at UEL, who will also be under an agreement to keep any information confidential
- The transcripts and any recording will be encrypted and password protected. After my thesis has been examined, the audio files will be deleted
- The written transcripts will be kept and destroyed after three years. The anonymised transcripts may be used to write up research in the future for publication, including a few quotes

What if I want to withdraw?

You are free to withdraw from the research study within two weeks of the interview without explanation, disadvantage or consequence. After that time, I will have begun my analysis and thus reserve the right to use material that you provide though I would not include any information that might identify you (e.g. quotes would be anonymised)

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me, Julie Baah

If you have any questions or concerns about how the research has been conducted, please contact the research supervisor Professor David Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ, Email: d.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: t.lomas@uel.ac.uk

Appendix G - Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Irina Anderson

SUPERVISOR: **David Harper**

STUDENT: Julie Baah

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: the experiences and role of mental health practitioners who have contributed as part of an interest group to submit evidence for the 2018 Mental Health Act (MHA) review

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved (but please note the possible differential responses from participants if variable data collection method goes ahead, ie, face-to-face interviews vs Skype)

Minor amendments required (for reviewer):

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (Typed name to act as signature):
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer (Typed name to act as signature): IA

Date: 12/2/20

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix H - Consent Form

University of East London

Pioneering Futures Since 1898

Participant Consent Form

Organisations' contributions to the 2018 review of the Mental Health Act: Social processes, racial disparities and the role of stakeholders

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent, I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………….

Participant's Signature

…………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………………..

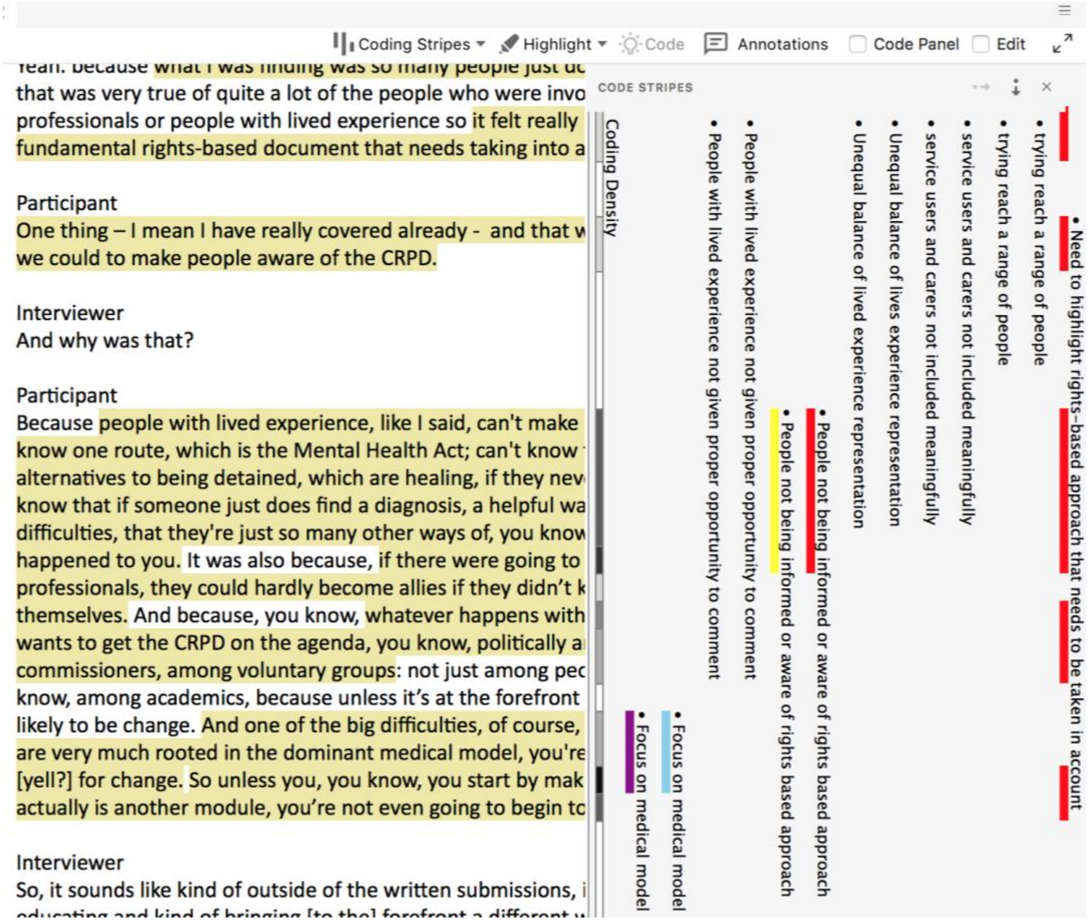
Researcher's Signature

……………………………………………………………………………………………

Date: ……………………..…….

Appendix I - Coded Transcript - NVivo

Example of initial coded transcript in NVivo



Yeah. because what I was finding was so many people just dc
that was very true of quite a lot of the people who were invo
professionals or people with lived experience so it felt really
fundamental rights-based document that needs taking into a

Participant
One thing – I mean I have really covered already - and that w
we could to make people aware of the CRPD.

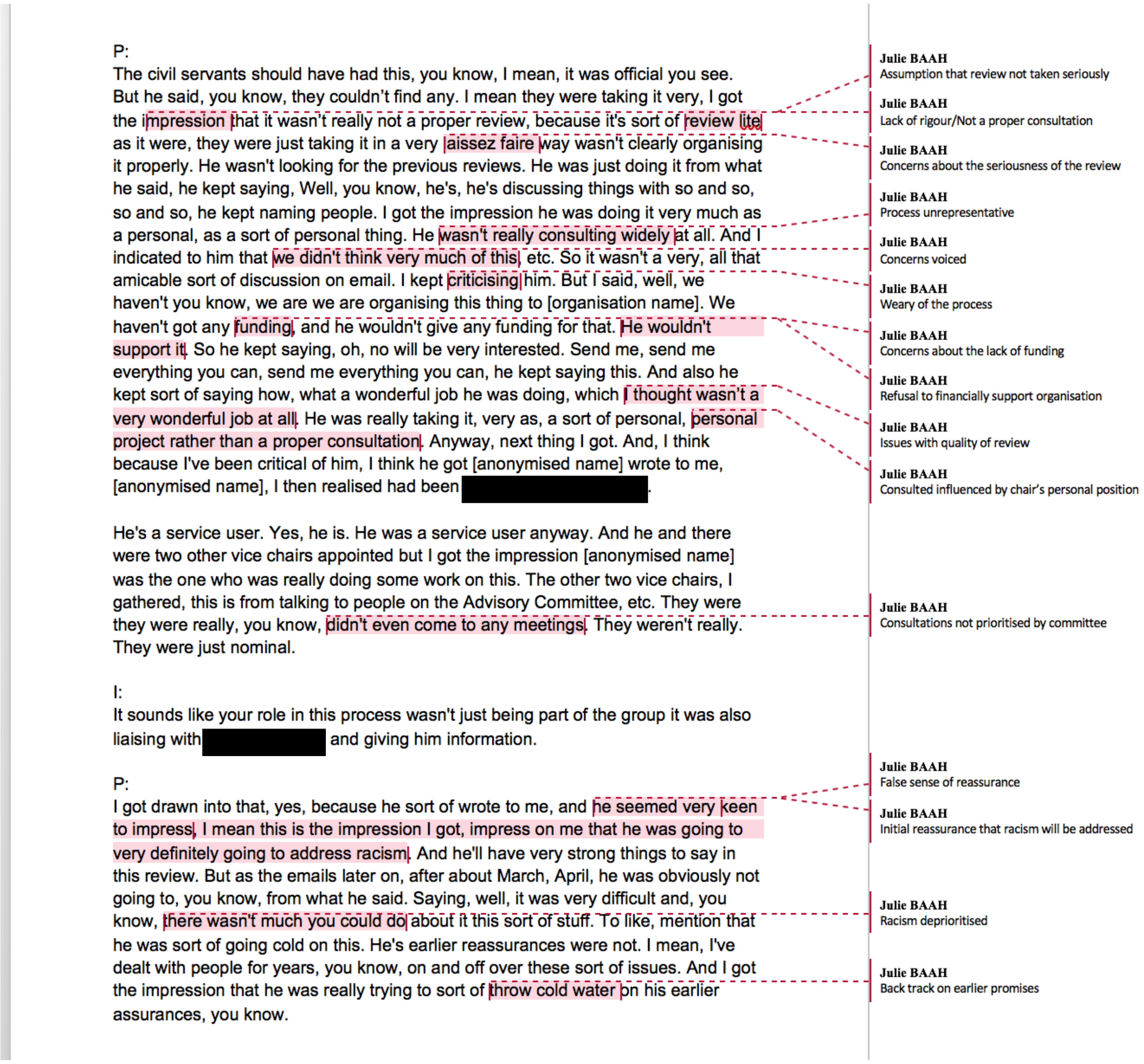
Interviewer
And why was that?

Participant
Because people with lived experience, like I said, can't make
know one route, which is the Mental Health Act; can't know
alternatives to being detained, which are healing, if they nev
know that if someone just does find a diagnosis, a helpful wa
difficulties, that they're just so many other ways of, you know
happened to you. It was also because, if there were going to
professionals, they could hardly become allies if they didn't k
themselves. And because, you know, whatever happens with
wants to get the CRPD on the agenda, you know, politically a
commissioners, among voluntary groups: not just among pec
know, among academics, because unless it's at the forefront
likely to be change. And one of the big difficulties, of course,
are very much rooted in the dominant medical model, you're
[yell?] for change. So unless you, you know, you start by mak
actually is another module, you're not even going to begin tc

Interviewer
So, it sounds like kind of outside of the written submissions, i
educating and kind of bringing [to the] forefront a different w

Appendix J - Coded Transcript – Microsoft Word

Example of initial coded transcript reproduced in Microsoft Word – identifiable names redacted



P:
The civil servants should have had this, you know, I mean, it was official you see. But he said, you know, they couldn't find any. I mean they were taking it very, I got the impression that it wasn't really not a proper review, because it's sort of review lite as it were, they were just taking it in a very laissez faire way wasn't clearly organising it properly. He wasn't looking for the previous reviews. He was just doing it from what he said, he kept saying, Well, you know, he's, he's discussing things with so and so, so and so, he kept naming people. I got the impression he was doing it very much as a personal, as a sort of personal thing. He wasn't really consulting widely at all. And I indicated to him that we didn't think very much of this, etc. So it wasn't a very, all that amicable sort of discussion on email. I kept criticising him. But I said, well, we haven't you know, we are we are organising this thing to [organisation name]. We haven't got any funding, and he wouldn't give any funding for that. He wouldn't support it. So he kept saying, oh, no will be very interested. Send me, send me everything you can, send me everything you can, he kept saying this. And also he kept sort of saying how, what a wonderful job he was doing, which I thought wasn't a very wonderful job at all. He was really taking it, very as, a sort of personal, personal project rather than a proper consultation. Anyway, next thing I got. And, I think because I've been critical of him, I think he got [anonymised name] wrote to me, [anonymised name], I then realised had been [redacted].

He's a service user. Yes, he is. He was a service user anyway. And he and there were two other vice chairs appointed but I got the impression [anonymised name] was the one who was really doing some work on this. The other two vice chairs, I gathered, this is from talking to people on the Advisory Committee, etc. They were they were really, you know, didn't even come to any meetings. They weren't really. They were just nominal.

I:
It sounds like your role in this process wasn't just being part of the group it was also liaising with [redacted] and giving him information.

P:
I got drawn into that, yes, because he sort of wrote to me, and he seemed very keen to impress, I mean this is the impression I got, impress on me that he was going to very definitely going to address racism. And he'll have very strong things to say in this review. But as the emails later on, after about March, April, he was obviously not going to, you know, from what he said. Saying, well, it was very difficult and, you know, there wasn't much you could do about it this sort of stuff. To like, mention that he was sort of going cold on this. He's earlier reassurances were not. I mean, I've dealt with people for years, you know, on and off over these sort of issues. And I got the impression that he was really trying to sort of throw cold water on his earlier assurances, you know.

Julie BAAH
Assumption that review not taken seriously

Julie BAAH
Lack of rigour/Not a proper consultation

Julie BAAH
Concerns about the seriousness of the review

Julie BAAH
Process unrepresentative

Julie BAAH
Concerns voiced

Julie BAAH
Weary of the process

Julie BAAH
Concerns about the lack of funding

Julie BAAH
Refusal to financially support organisation

Julie BAAH
Issues with quality of review

Julie BAAH
Consulted influenced by chair's personal position

Julie BAAH
Consultations not prioritised by committee

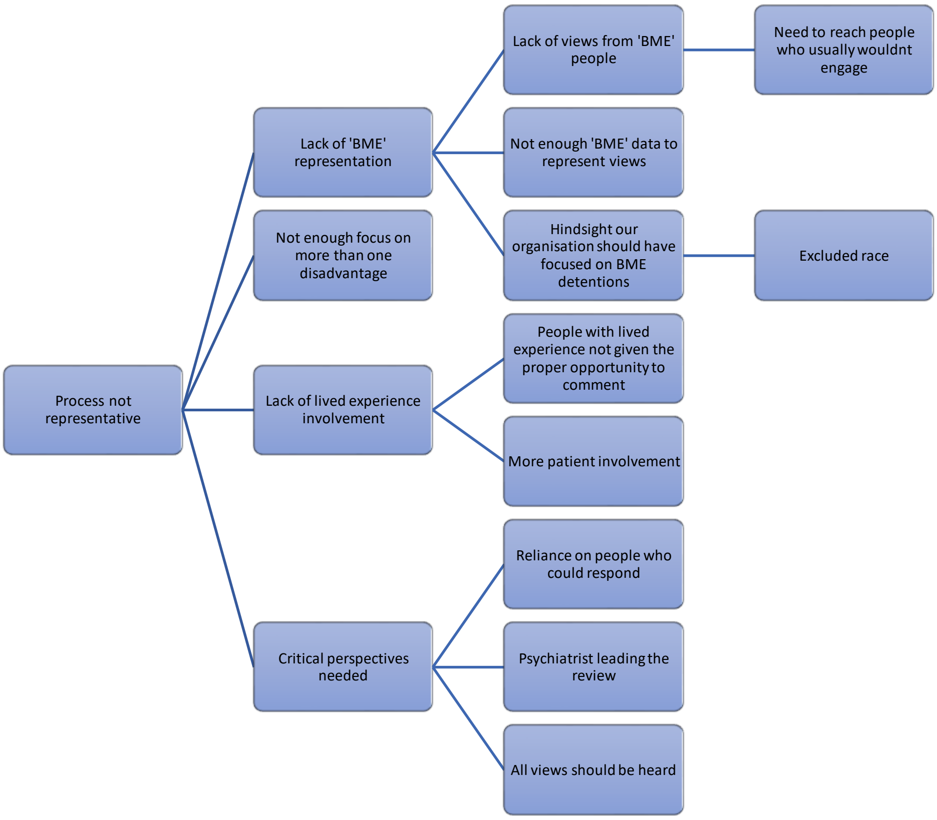
Julie BAAH
False sense of reassurance

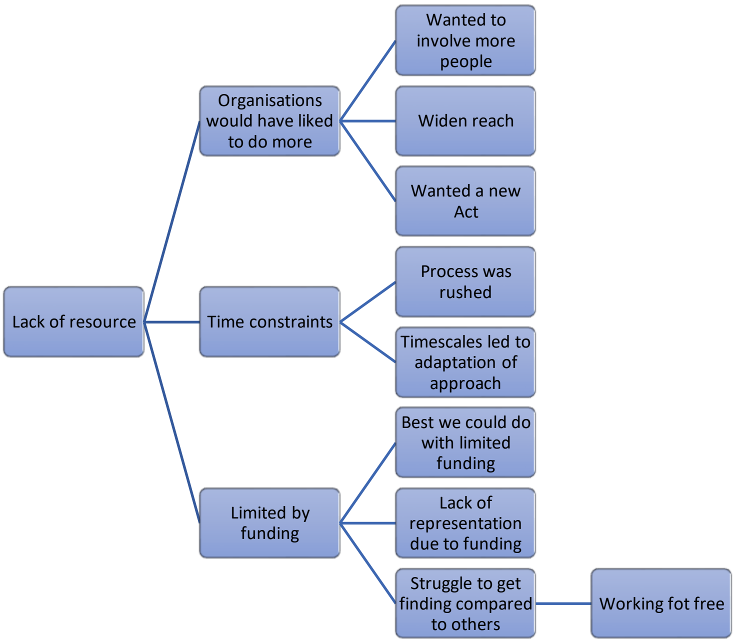
Julie BAAH
Initial reassurance that racism will be addressed

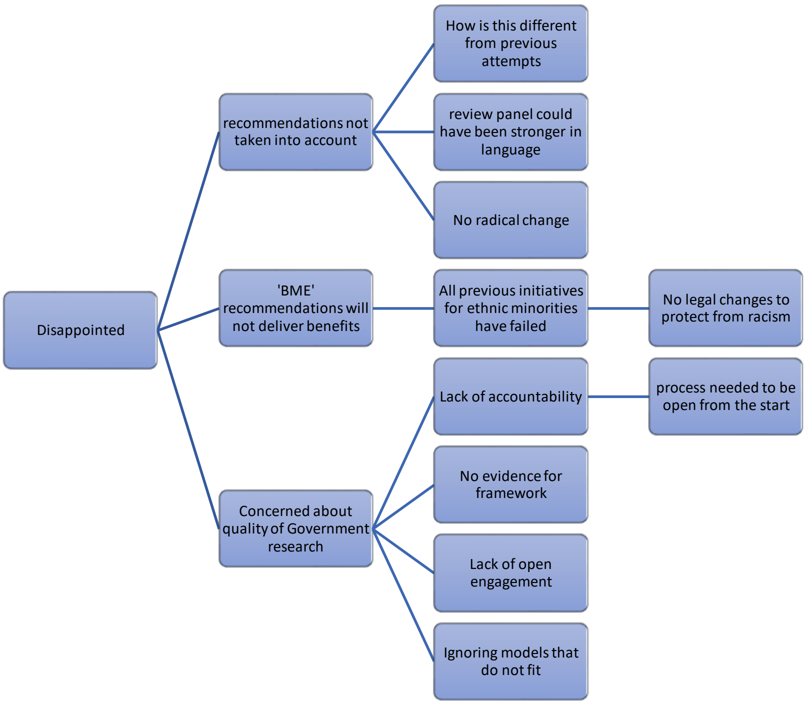
Julie BAAH
Racism deprioritised

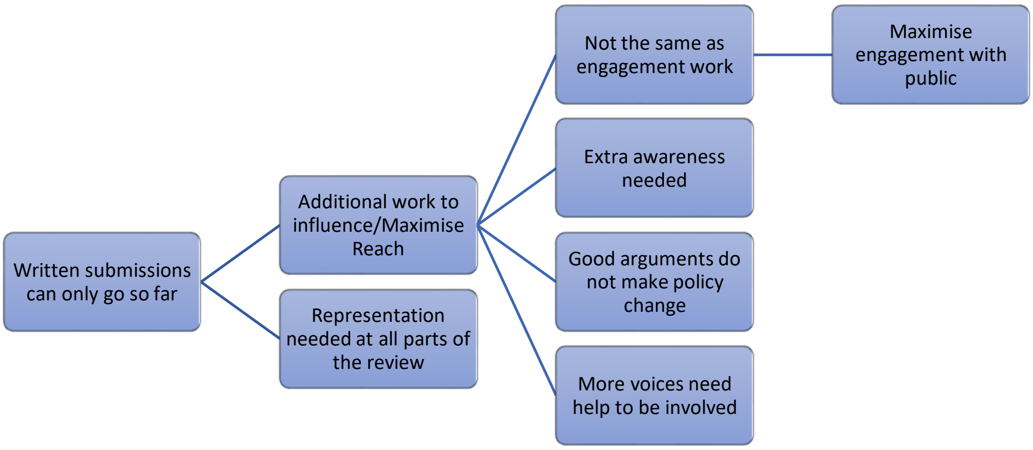
Julie BAAH
Back track on earlier promises

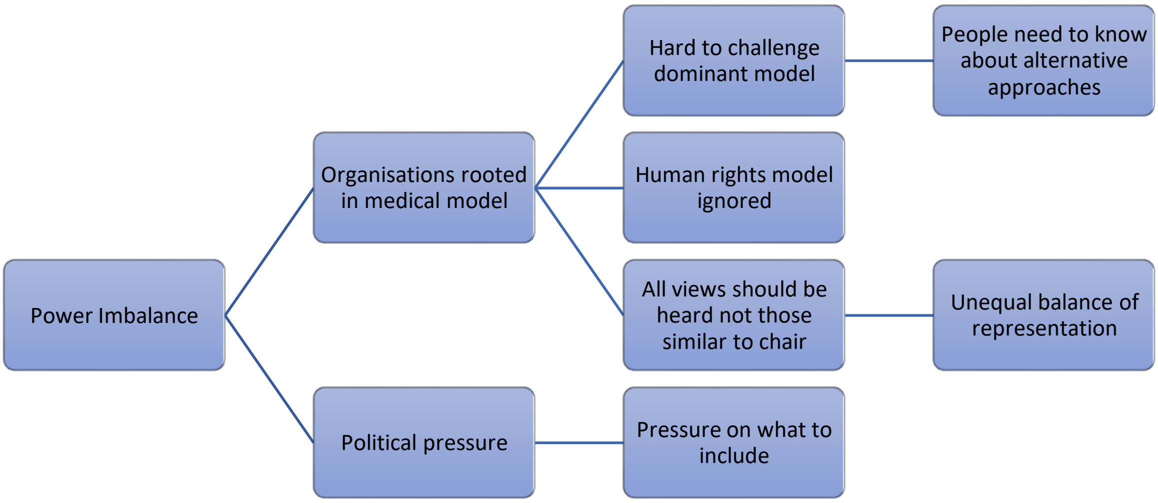
Appendix K - Example of Initial Maps



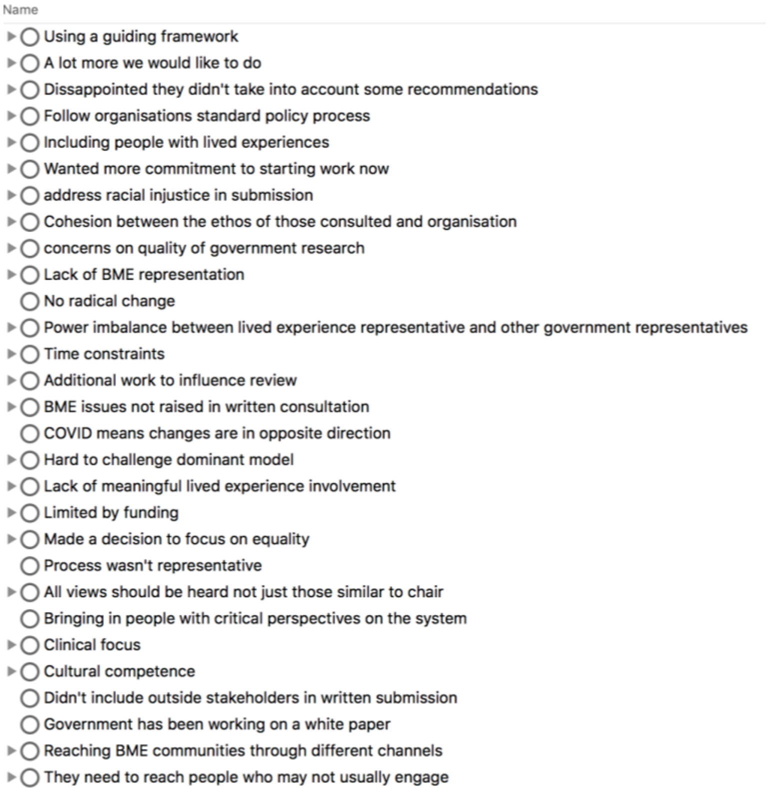



Disappointed
recommendations not taken into account
How is this different from previous attempts
review panel could have been stronger in language
No radical change
'BME' recommendations will not deliver benefits
All previous initiatives for ethnic minorities have failed
No legal changes to protect from racism
Concerned about quality of Government research
Lack of accountability
process needed to be open from the start
No evidence for framework
Lack of open engagement
Ignoring models that do not fit


Written submissions can only go so far
Additional work to influence/Maximise Reach
Not the same as engagement work
Maximise engagement with public
Extra awareness needed
Good arguments do not make policy change
More voices need help to be involved
Representation needed at all parts of the review

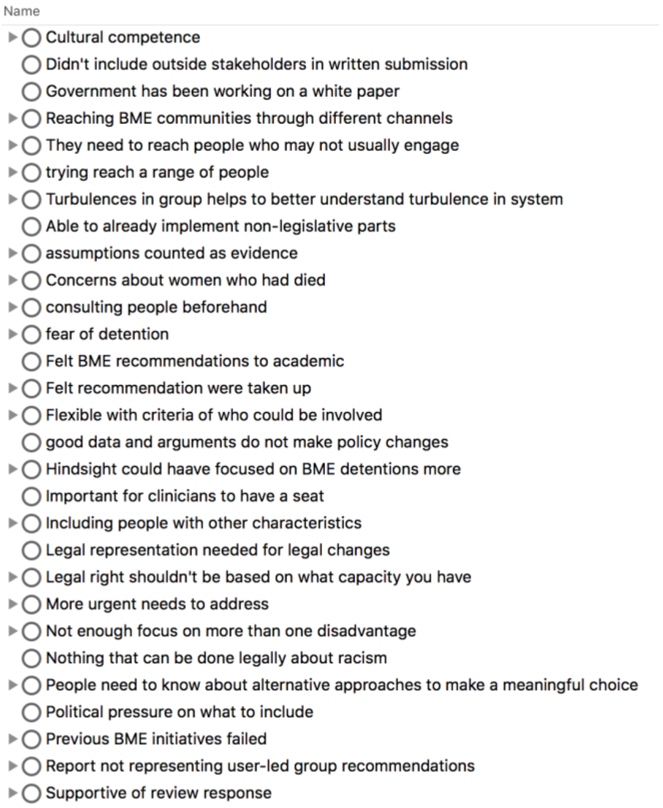

Power Imbalance
Organisations rooted in medical model
Hard to challenge dominant model
People need to know about alternative approaches
Human rights model ignored
All views should be heard not those similar to chair
Unequal balance of representation
Political pressure
Pressure on what to include

Appendix L - Example of Initial codes - NVivo



Name

▶ ○ Using a guiding framework
▶ ○ A lot more we would like to do
▶ ○ Dissappointed they didn't take into account some recommendations
▶ ○ Follow organisations standard policy process
▶ ○ Including people with lived experiences
▶ ○ Wanted more commitment to starting work now
▶ ○ address racial injustice in submission
▶ ○ Cohesion between the ethos of those consulted and organisation
▶ ○ concerns on quality of government research
▶ ○ Lack of BME representation
○ No radical change
▶ ○ Power imbalance between lived experience representative and other government representatives
▶ ○ Time constraints
▶ ○ Additional work to influence review
▶ ○ BME issues not raised in written consultation
○ COVID means changes are in opposite direction
▶ ○ Hard to challenge dominant model
▶ ○ Lack of meaningful lived experience involvement
▶ ○ Limited by funding
▶ ○ Made a decision to focus on equality
○ Process wasn't representative
▶ ○ All views should be heard not just those similar to chair
○ Bringing in people with critical perspectives on the system
▶ ○ Clinical focus
▶ ○ Cultural competence
○ Didn't include outside stakeholders in written submission
○ Government has been working on a white paper
▶ ○ Reaching BME communities through different channels
▶ ○ They need to reach people who may not usually engage



Name

▶ ○ Cultural competence
○ Didn't include outside stakeholders in written submission
○ Government has been working on a white paper
▶ ○ Reaching BME communities through different channels
▶ ○ They need to reach people who may not usually engage
▶ ○ trying reach a range of people
▶ ○ Turbulences in group helps to better understand turbulence in system
○ Able to already implement non-legislative parts
▶ ○ assumptions counted as evidence
▶ ○ Concerns about women who had died
▶ ○ consulting people beforehand
▶ ○ fear of detention
○ Felt BME recommendations to academic
▶ ○ Felt recommendation were taken up
▶ ○ Flexible with criteria of who could be involved
○ good data and arguments do not make policy changes
▶ ○ Hindsight could haave focused on BME detentions more
○ Important for clinicians to have a seat
▶ ○ Including people with other characteristics
○ Legal representation needed for legal changes
▶ ○ Legal right shouldn't be based on what capacity you have
▶ ○ More urgent needs to address
▶ ○ Not enough focus on more than one disadvantage
○ Nothing that can be done legally about racism
▶ ○ People need to know about alternative approaches to make a meaningful choice
○ Political pressure on what to include
▶ ○ Previous BME initiatives failed
▶ ○ Report not representing user-led group recommendations
▶ ○ Supportive of review response

Appendix M – Title Amendment to Ethics Application

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.
Type your name in the 'student's signature' section (page 2).
When submitting this request form, ensure that all necessary documents are attached (see below).
Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
Recruitment and data collection are not to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
A copy of the approval of your initial ethics application.
Name of applicant: Julie Baah
Programme of study: Professional Doctorate in Clinical Psychology
Title of research: The experiences and role of mental health practitioners who have contributed as part of an interest group to submit evidence for the 2018 Mental Health Act (MHA) review

Name of supervisor: Professor David Harper

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Title to change from: the experiences and role of mental health practitioners who have contributed as part of an interest group to submit evidence for the 2018 Mental Health Act (MHA) review New title: Organisations' contributions to the 2018 review of the Mental Health Act: Social processes, racial disparities and the role of stakeholders	The new title is shorter which was recommended by the research director following a review of the research proposal. The new title also matches the title on the information sheet and consent forms in the ethics application. The new title more accurately reflects the research which will be conducted.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Julie Baah

Date: 13.02.2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	

Comments		

Reviewer: Tim Lomas

Date: 13.2.20