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Professional experiences on use of the mental health act in ethnically diverse populations: a photovoice study

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ABSTRACT

Background There are long-standing ethnic and racial inequalities in experiences and outcomes of severe mental illness, including compulsory admission and treatment (CAT).

Aims To gather professional experiences about (1) remedies for ethnic inequalities in the use of the Mental Health Act (MHA) 1983 and 2007) and (2) recommendations for improving care experiences and for reducing ethnic inequalities.

Method We undertook a participatory research process using photovoice to gather experience data. Photographs were assembled and narrated by 17 professionals from a variety of disciplines. We undertook a thematic analysis.

Results Ineffective communications between inpatient and community services, insufficient staff capacity, a lack of continuity of care and language and cultural constraints meant MHA assessments were lacking information, leading to elevated perceptions of risk. Practitioners felt helpless at times of staff shortages and often felt CAT could have been prevented. They felt voiceless and powerless and unable to challenge stereotypes and poor practice, especially if they were from a similar demographic (ethnicity) as a patient. Interdisciplinary disagreements and mistrust led to more risk-averse practices. The legislation created an inflexible, risk-averse and defensive process in care. Police involvement added to concerns about criminalisation and stigma. There were more risk-averse practices when team members and families disagreed on care plans. More rehabilitation and recovery-orientated care are needed. Legislative compliance in a crisis conflicted with supportive and recovery-orientated care.

Conclusion Clear standards are needed, including specific protocols for MHA assessment, police interactions, alternatives to admission, early intervention and continuity of care.

BACKGROUND

In Europe and North America, ethnic minorities and migrants experience more adverse pathways to mental healthcare, including higher rates of compulsory admission and treatment (CAT), more contact with the police and criminal justice agencies, as well as poorer long-term outcomes compared with white British people.^{1–8} CAT increases stigma, fear, avoidance of mental health services and feelings of powerlessness, and therefore it undermines

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The levels of compulsory admission and treatment (CAT) are rising, and ethnic and racial disparities in the level of detention persist. Practitioners' experiences of using mental health legislation hold valuable information on how to reduce ethnic and racial disparities, yet their views are rarely sought for innovations in policies and practice.

WHAT THIS STUDY ADDS

⇒ Practitioners identified several reasons why ethnic and racial disparities persist, including increased risk perception due to interdisciplinary mistrust and poor communication, family discord and a lack of information due to language and cultural constraints. Police involvement led to escalation, and police and mental health practitioner roles were not always clear, leading to frustration. The emotionally demanding work of caring for people with severe mental illness and then undertaking CAT often involved disagreement and led to fatigue and failure to consider all options at the time of assessment. Defensive practice, delays in assessment, a lack of continuity of care and staff shortages all add to imperfect decision-making and escalation to CAT rather than other options.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Improving legislation alone will not reduce ethnic and racial disparities in CAT; rather, a comprehensive range of community services, skilled interdisciplinary communication and decision-making, less escalation to police involvement, and tackling staff shortages are all essential. Culturally competent care also requires better skills in assessing across language and cultural barriers, as well as involving family in decisions.

autonomy, agency and the recovery of patients.^{9–12} Patients find CAT distressing and frightening, especially due to the threat of and actual use of force, restraint and seclusion, although providing clear information in a collaborative relationship can be helpful.¹³ Black people in particular feel decisions



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are made by others, and they are mistreated, although admission can be helpful.¹⁴

Mental health legislation permits CAT in many countries around the world; the legislation is intended to codify when and how patients may be detained. In so doing, its purpose is to protect the human rights of the patient while guiding clinicians to follow transparent and legally specified processes that include safeguards. However, there is much dissatisfaction with mental health legislation as recommended procedures are not always followed.¹⁵ Ethnic inequalities in the use of CAT raise concerns about bias in assessments and judgements about risk. They raise concerns about societal and institutional racism and whether the wider social determinants and systems of care are racially, ethnically and culturally unfair. Risk assessment is rarely predictive and is bedevilled by a lack of agreement between assessors and unconscious bias.^{16–19} Furthermore, relatives' views may not align with those of patients or professionals, creating uncertainty at a time of crisis.¹⁸

An independent review of the Mental Health Act ((MHA), England and Wales) made recommendations that might reduce ethnic inequalities in CAT. It also recommended more experience-based research, especially from service users and professionals involved in applying the MHA. Research can expose mechanisms and processes that result in higher detention rates in some groups and not others and inform how legislation and care might be improved, alongside actions to reduce the use of CAT.¹² Lived experience expertise is beginning to challenge conventional paradigms of research and care through new insights; however, professional perspectives are also important as these too can provide important insights. Not least, professionals involved in implementing the MHA will have knowledge gathered over many years of practice, from different settings and for many different populations. This study reports on professionals' experiences of MHA use in ethnically diverse populations. We did not find any other studies using photovoice (PV) or even taking an experience-driven approach to staff data.

Aims

To assemble the experiences of professional stakeholders from multiple disciplines to:

- ▶ Offer potential solutions to reduce ethnic inequalities in CAT.
- ▶ Make recommendations to improve legislation, practice and policy and support people subject to CAT.

METHODS

Methodological innovation

Understanding what drives inequalities is challenging. Qualitative research offers a powerful approach to discover novel interacting drivers of inequalities; for example, it has been used to explain the clustering of diabetes, depression and HIV by ethnicity and gender.^{20–23} Crenshaw's intersectional approach,^{3 23 24} in particular, looks at gender violence and how research and practice do not often engage with the role of race and class, as if these were mutually exclusive influences.²⁵ She goes on to say, 'Although racism and sexism readily intersect in the lives of real people, they seldom do in feminist and antiracist practice'.²⁵ Thus, her emphasis is on variations with groups and the intersecting influences of different categories of identity and experience. More recently, intersectional studies link social categories of identity with contexts, systems and structures of power, and power inequality, producing unique lived experiences.²⁶

We adopt this approach to expose how inequalities in the MHA arise at the 'intersections' of multiple coexisting identities and forms of disadvantage. At the heart of this type of research lies the curiosity to ask people affected by poor health about their experiences and value these as a window to new information about aetiology, mechanisms and risk and protective factors. Lived experience research is now recognised to hold important lessons for service development and for improving care.^{27–29} What little research there is on the use of mental health legislation, mostly hears from the people who are detained and their families and carers, rather than the clinicians and practitioners who provide care for them.^{30 31}

Gathering experiential data presents its own challenges, as people vary in their willingness and ability to recount events, especially if these are experienced as stressful or traumatic or if they fear criticism and allegations of poor professional practice. In this study, we were guided by a systematic review of participatory methods, which identified PV as a promising approach for such research.³² PV involves participants taking photographs of anything that helps them think about or explore their views about the research topic. The photographs engage participants in a creative and reflective process of perspective-taking, permitting iterative deepening and exploration of narratives through conversation. PV disrupts the traditional power relationships between researcher and participant, as the creative task involves conversations—sharing power by starting from first principles for everyone—social connections—and thinking together about experiences. Thus, people with lots of expertise in one area are not assumed to have expertise in all areas, and the voice of service users is given significant priority. The emerging narratives are deepened over time and can expose care experiences that warrant remedy as well as intersectional mechanisms that might be targeted in preventive work.^{33 34}

Setting and participants

Participants were recruited across eight NHS trusts (London, Birmingham, Manchester, Leeds, Bradford, Oxford, Derby and Lancashire) where patients were also being recruited to take part in PV workshops around their MHA experiences. Adverts were shared across the NHS trusts inviting anyone who worked with people detained under the MHA to take part. These were shared on staff intranets, at board meetings and in inequalities initiative groups. Researchers from Oxford worked closely with local research and development offices to ensure that adverts were reaching diverse staff groups and that we recruited a range of professions and ethnicities.

Data collection

Workshops were held online, and staff were consented to individual team meetings in advance. Two workshops were held; the first consisted of an induction session, providing information about the study, photo ethics and information around how to caption images. We did not instruct on what images to take, other than caution around hospital premises and pictures of other people requiring their permission. After this workshop, participants sent images and captions to the study team using either email or WhatsApp. We offered to post disposable cameras to participants (as these were being used in patient workshops), but all participants opted to use their own smartphones to take images. In the second workshop, participants shared their photographs using an online platform called Padlet (including captions, summaries and images) to deepen their reflections and identify key moments where different decisions and actions

Table 1 Demographic information

Ethnicity	White British	11
	Pakistani	3
	Sri Lankan	1
	African	1
	Indo-Caribbean	1
Profession	Psychiatrist	3
	Nurse	4
	Psychologist/psychotherapist	3
	Occupational therapist	2
	Social worker	1
	Manager	4

might have changed or improved their experiences and patient outcomes. Researchers kept field notes to guide the pace and scope of ongoing discussion. Audio from the second workshop was transcribed verbatim. Workshops were led by RM, a woman of colour and a senior postdoctoral qualitative researcher with a background in health psychology and inequalities.

Data analysis

The data consisted of photos, captions and recordings of meetings, which were transcribed, and these transcripts formed the basis of analysis; these were analysed by holding transcripts in MAXQDA (a qualitative software package) and manually reviewing digital transcripts and images. The narratives in part reflected these elaborations of the experiences represented by photographs, but more often, there was a general discussion around what CAT is like and their role as professionals. Thus, the photographs served as a photo-elicitation prompt.

We analysed the narratives more generally, and where images were referred to, we presented these alongside the thematic structure that emerged. Yet, many images were not related to the overall thematic structure (a full set of images is available on request).

The initial analysis involved coding of experiences and narratives, pictures and captions from professionals in the workshops. We carried out a thematic analysis (TA), as described by Braun and Clarke,³⁵ as a method for identifying, analysing and reporting patterns within data. We also drew on the principles of polytextual TA. Participants considered the image data in group discussion, assessing it for meaning and context, and it was these narratives that entered the TA.³⁶ Then, we undertook the following steps: viewing images and captions, reading transcripts of emergent narratives, familiarisation, searching for codes and higher-order common themes and important uncommon themes, reviewing and refining themes, and reporting. Analysis was conducted by RM and KB and iterated with the broader project team.

Reflexivity was built into the process, as at each stage, interpretation was by the participants viewing their own and others' data to produce narratives. However, there are no standard methods in photovoice analysis, hence we set out the adapted procedures. TAs were reviewed and refined by the investigators, including the peer researchers. KB holds a research doctorate (MD) and is a male Kenyan-born psychiatrist of Punjabi Sikh Indian heritage, and RM holds a PhD and is a woman of Indian and Irish heritage. KB and RM have undertaken extensive qualitative research in their doctorates and subsequently (over 25 and 10 years). However, there are no standard methods in photovoice analysis, hence setting out the adapted procedures. KB and RM

Box 1 Summary of critical insights

Care systems

- ⇒ Distances people were transported for care
- ⇒ Continuity of care undermined by staffing and multiple teams and bank staff.
- ⇒ Staff shortages and insufficient time: harm continuity and considered decision-making in crisis.
- ⇒ Escalation (sometimes inappropriately) to police involvement rather than a crisis response in mental health care.
- ⇒ Admission in response to the crisis restricting decision options.
- ⇒ Mental health legislation restricts the range of options.
- ⇒ Legislation creates defensive practice and relegates other 'care' aspirations.
- ⇒ Moral and role conflict for clinicians operating in accord with legislation knowingly conflicting with identities and roles as caring clinicians.
- ⇒ Failure to prevent and provide timely interventions, even when sought.

Professional capabilities

- ⇒ Fair treatment is important.
- ⇒ Three people making the judgement was good.
- ⇒ Concern for patients being forced into treatment and needing to be admitted.
- ⇒ Feeling injustice of not providing early care and then CAT.
- ⇒ Minority staff felt voiceless, helpless and unable to advocate for patients of their ethnicity.
- ⇒ Respite to defend against emotionally demanding work meant crisis presentation was inevitable.
- ⇒ Counterfactuals are not considered in group decisions due to group pressure.
- ⇒ Historical risk judgements dominate.
- ⇒ Limited information if there are cultural and linguistic constraints—add to risk judgement.
- ⇒ Interdisciplinary mistrust and poor communication heighten risk judgements.
- ⇒ Family disagreements heighten risk judgements.

Societal influences

- ⇒ Police role as a public service.
- ⇒ Stigma and fear and distress.
- ⇒ Societal racism and prejudice.
- ⇒ First contact with police was felt as criminalising.
- ⇒ Unconscious bias and structural racism.

reflected on notions of identity and influences on interpretation throughout the study, and conclusions were also interrogated by investigators and lived experience experts in the research.

RESULTS

Participants

There were 10 men and 7 women, with ages ranging from 26 to 51; career durations in these roles ranged from 1 month to 15 years. The ethnic and professional backgrounds of the participants are presented in [table 1](#).

Images and captions

We present a selective number of images and captions to illustrate themes.

Coding the data and consistency

We identified 322 individual detailed codes, of which 305 overlapped between two coders; these were verified by a third reviewer, and differences were reconciled. Higher-order themes were inductively generated and grounded in the data and in the synthesis. Below, we present our findings, *italicising* elements that suggest *mechanistic* targets for improving care quality and prevention of CAT. There were three high-level themes and many more subthemes (see box 1).

1. Service operation and care pathways.
2. Professional capabilities and experiences.
3. Societal, health and social structures.

Images and captions: service operation and care pathways

OK, so this is an effective and quick way of putting out an electrical fire and hopefully making it safe. However, it makes a lot of mess and often the electrical thing that was on fire is damaged pretty badly. There's a lot of clearing up to do, things may not be quite the same after and there's a period of anxiety afterwards. (M, 35–44, White British; figure 1)

I just feel sometimes I lose a good connection with service users I have taken lengths to engage with it starts to get more complicated, more messy and with some loose connections to try and tie up. Things get added in from other services, other parties, which doesn't always join up and feels like it is making things more confusing for the service user. (M, 35–44, White British; figure 2)

When someone is detained when they are forced to go unplanned under the MHA their lives maybe in chaos they may be isolated fearful and sometimes there's a cat left curled up on the sofa waiting for the heating to go on or a big dog delighted to see you sometimes, there has even been cattle and horses—these creatures may have been soothers, companions, security but what happens to them when you are removed from your home. This issue causes ripples of drama and debate as pet care costs become an issue when the owner is in hospital. It's an added worry, stress, intrusion but it has to be addressed. I would like there to be a joint discussion with mental health charities like MIND, animal charities like PSDA and NHS so people can know their pets are being cared for while they get the care and treatment they need to be able to look after themselves and their pets again. (F, 45–54, White British; figure 3)



Figure 1 Putting out fires.



Figure 2 Connection and disconnection.

Images and captions: Professional capabilities and experiences

I witnessed staff handling dementia patients very aggressively at a hospital in London. These patients were struggling with their mental health and so scared coming into hospital. Many were spoken to in an unacceptable fashion. It was, despicable, disturbing and very frustrating to see that this was the ward culture. No humanity. Truly heart breaking. Not only did I feel that the patients had their hands tied but also felt my hands were tied as staff did not understand how to treat patients with compassion and dignity. The right of every human being. (F, 35–54, Black British; figure 4)

A detained service user said to me 'When a white man throws a chair he gets sent to his room. When a black man throws a chair he gets restrained, injected, sent to PICU and locked in a room alone for two days'. Can this be true? I don't want this to be true. I struggle to accept that it may be true Sadly, I know this is very often true. Why is this true? How can we make this less true? (M, 45–54, White British; figure 5)



Figure 3 Pets.



Figure 4 Restraint.

I chose this as it looks quite soft and fluffy but is really annoying and prickly. I guess I am an OT, trying to engage with service users by building relationships, gaining trust with people who are often very unsure and wary about trusting others. Trouble is, in my role I'm also there with my risk and safety hat on and that side of things definitely gets prickly. Feels like there are two sides to what I'm doing sometimes and that can be hard to reconcile. (M, 35–44, White British; [figure 6](#))

Images and captions: societal, health and social structures

Same environment. Some trees flourish, some are dead and dying. I wish we could have the same experiences but alas, who you are, where you are and how you look determines if you would flourish or struggle. ([figure 7](#))

I was on leave and on a trip to London; we all went to the science museum. I came across a corner dedicated to the advances in practice in mental health. These images of physical restraints were shocking and in the information it seemed to suggest that advances had been made with the introduction of 'chemical restraints'. This made me think of some of the assessments I have completed when someone is on a section 2 and there is a request to go onto a section 3. It's awful to see people struggling to move due to the medication they have been given, or describing not feeling right inside. I see this a lot with the men we work with in Bradford City who are mostly from BAME backgrounds and often come into the service with incidents of aggressive or challenging behaviour. It made me



Figure 5 Race stereotypes.

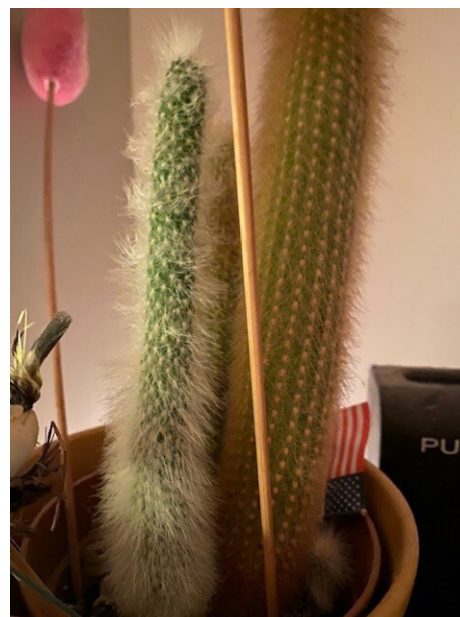


Figure 6 Soft, fluffy, annoying, prickly.

think about in another 50 years, will there be pictures of depots and lists of side effects displayed with information about better/newer ways of supporting people. Hope so! (M, 45–54, White British; [figure 8](#))

TA: services and care pathways

There was consistency in narratives and themes across participants. Specifically, patients were sometimes *transported far from home*, and this was not helpful for recovery and made family visits difficult. *Large caseloads* prohibited more time being spent on individual patient care. *Limited time* meant *concerns were not worked through and resolved* during MHA assessments; crises thus ended up a self-fulfilling prophecy, and CAT was recommended.

There was no *continuity of care* due to the number of teams and interfaces between different services, the very common use of 'bank' staff (non-regular staff working to cover vacancies and uncovered shifts) and many different staff interacting with patients even in one service. Assessments under the MHA were limited when there were *cultural and language constraints*, leading to *elevated perceptions of risk*; more nuanced contemporary information was not always available or gathered to better inform a more personalised and contextualised decision. *Risk assessment was then dominated by historical incidents*, rather



Figure 7 Flourishing or dying.



Figure 8 Physical restraint.

than being based on more recent and contemporary information. Therefore, *stereotypes* came into play. There was an acceptance of *unconscious bias* (eg, if someone throws a chair, it will be *differently interpreted if done by a black man* rather than a white man). A white middle-aged male participant explained how if a black person walked back and forth looking agitated, the tendency was to anticipate escalation.

This person isn't taking their meds usually that was the situation, this person, particularly in some time we need to get team in together. Now this person is going to become aggressive. That was quite a common theme but quite often we you know it was what why are we not using our skills of the fact that we've known these people for a long time. If the people have been admitted. They're quite some time and we could, you know, deescalate and resolve the situation without needing that restrictive practice officer called intervention. (F, 15–24, British Pakistani).

Staff acknowledged that help for patients was often *offered too late* to avert a CAT episode. *People were refused help* when they sought care and ended up in crisis and then were forced to have care as if it was inevitable or their fault. Participants were left feeling this was unjust. Participants felt that assessments *attempted to be fair*, in that there were *three people* making a judgement about suitability for detention, and this was a built-in opportunity to question. However, *counterfactuals were rarely entertained*, and it was uncommon to consider all options, suggesting *group pressures* led to decisions that were not critically considered. Discontinuous care and insufficient time to work with patients in the community, or consider all the information, all added to perceptions of elevated risk, along with a failure to act early, and so each added to the likelihood of a CAT episode following assessment.

TA: professional capabilities, skills, attitudes and experiences

Professionals from the same ethnic or racial demographic as the patient felt *voiceless, isolated* and unable to speak up on behalf of the patient and felt *helpless* to change the prevailing views and ways in which decisions were weighed.

Staff members experience the exact thing, you know, that, that feeling of helplessness, that feeling of not being able to kind of

communicate accurately or how to articulate themselves and what not. And I think that that that's a really important point to make when detaining people under the act. (F, 45–54, Indian Caribbean)

There were *conflicts in expected and experienced roles*, for example, between a person who wanted to provide good care versus *care being limited to following the MHA procedures*.

...the cactus one. I think there's this tension between. For that I really identify with that tension of. Doing what you think might be helpful and doing what you're legally obliged to do. (M, 25–34, White British).

Participants felt assessments then *focused on risks, anticipating blame and fears about adverse outcomes*, such as a fatality. CATs happened even if it was felt to be unhelpful because of defensive practice and role strain. Professionals felt unable to take the risk of not admitting in crisis, one person citing an example of a death following non-admission. Participants were saddened when people asked for help and were turned away, and then they ended up being forced to receive crisis treatment, which was distressing through no fault of their own.

Participants acknowledged the *importance of treating people well and fairly* and did not feel they always achieved this. Interestingly, multidisciplinary decision-making was proposed to be important to improve risk assessment and care planning. However, a lack of *interdisciplinary skills and mutual trust* made people risk-averse, and a CAT episode was more likely in such instances. Furthermore, there was *insufficient risk dialogue with patients*, who did not understand how judgements about them were being constructed and why they were detained and might be secluded.

The work was *emotionally demanding*, especially if there was disagreement with families or when the staff themselves felt under pressure (time, risk and powerlessness). They described a process of passively accepting *disengagement for respite*, knowingly awaiting the next crisis. This was described as a form of *resting away from the pressures of work* and demands placed upon them. People were very aware they might be *re-enacting a rejection* from an early phase of life for the patient through the application of standard procedures. In this context, when there were *communication breakdowns* with patients, it was not easy to restore connections. There were interesting recommendations to try and *connect through sharing films or books or through music and learn something about the person beyond their illness*.

TA: societal, health and social structures

The participants acknowledged wider societal issues and how mental healthcare was represented in the public imagination: stereotypes fed perceptions and stigma; they argued that we need better recovery-orientated dialogue and commensurate changes in society. Prejudice was proposed to be built into all processes; racism inevitably played a part, and therefore patients did not seek help. There was much discussion about the role of police and mistrust of services.

Taken to the services for the very first time. It's your first introduction to mental health services, and it's in the back of a police van..... almost like I've done a crime....I've done something wrong...with the black community, historical issues of the police...I'm reluctant to call the police...because it just makes it worse.(M, no age reported, White British)

There's fear or mistrust of mental health services...and it affects how people access crisis services. (F, 20–29, British Pakistani)

Police were often responsible for transporting people to a place of safety, when mental health professionals may be more appropriate. It was widely acknowledged that the relationships between the po-

lice and mental health professionals was fraught with ambivalence, power struggles, and keeping people safe was often forgotten. There's a frosty interface between the police and psychiatric services...it's a bit odd really...a bit of a power struggle there between professionals. (F, 30–39, British Pakistani)

DISCUSSION

This study sought to gather professional perspectives on how to prevent CAT and improve care experiences. Our findings show significant points of intervention (see [box 1](#)). These can be addressed by improved professional standards and training and care systems reforms, and some may be mitigated by advanced agreements and advocacy. A recent evidence synthesis sought to explain rising detentions in the UK, proposing a new explanatory model for rising CAT.³⁷ Our findings confirm some of the proposed mechanisms reported in that evidence synthesis:

- ▶ Defensive practice and concerns about the consequences of not admitting in crisis.
- ▶ Crisis and MHA assessment occurred too late, and there was little critical thinking or evaluation of alternatives and consideration of counterfactuals.
- ▶ Lack of continuity of care and insufficient community support.
- ▶ Staff shortages, the number of teams and bank or non-regular staff, all add to the lack of continuity.

Our findings add additional mechanisms:

- ▶ Interdisciplinary mistrust and lack of effective communication increase perceptions of risk.
- ▶ Family discord increases perceptions of risk.
- ▶ Police involvement led to escalation rather than prevention, ultimately ending in compulsory admission and treatment.
- ▶ Unclear roles and responsibilities between the police and mental health professionals make for imperfect decisions and frustrated relationships.
- ▶ Emotionally demanding work of MHA legislation and care for people when there is disagreement can lead to fatigue and failure to consider all options.
- ▶ Lack of sufficient information due to language or cultural constraints leads to perceptions of greater risk.
- ▶ Professionals (especially those from minority ethnic groups but generally also) are unable to object to group pressures and feel isolated and without a voice.
- ▶ MHA assessments prioritise the legal process and compliance, forcing codified decision options rather than a fuller range of personalised options.

Research of interventions and quality improvement strategies targeting these mechanisms may be able to prevent admission by strengthening actions earlier in the care pathway, as well as encouraging *critical and resistant* thinking at the time of the assessment. This may require longer assessment and consultation with the interpreters', family and general practitioner. There is also a need for skills in interdisciplinary working and ensuring mistrust and poor communication do not undermine optimal and least restrictive options.

Structural analysis

The findings draw attention to wider societal views, including stigma, prejudice and historical relations of police and ethnic minorities, all driving fear of services and undermining trust. These are important for two reasons: first, the lack of trust may not be overtly expressed but may lead to fear and conflict and a need for greater attention to how to address mistrust in a crisis. The second is that professionals identified some people who would not benefit from admission, yet they felt compelled

to follow legislative procedure somewhat dispassionately; in response, they felt a moral and ethical conflict in doing so. Professionals too were distressed. The professionals echo what patients have said for some time, and both seem entangled in a system that works for neither.^{13 38} How does this happen?

Bourdieu introduced an important concept of 'habitus', which Lo and Stacey elaborated on to understand cultural interactions in clinical care.³⁹ Habitus links cultures, contexts and social structures, and thus, the clinical encounter is a product of the health/social system, operating within the social structures and broader values that condition what takes place at all levels. Therefore, traditions are reproduced over time to functionally adapt, but these then sustain the very challenges and harms that progressive policy and practice seek to mitigate. Thus, there is a need for resistance and critical reflection, which is hard in a crisis.

We previously used the notion of habitus in understanding how to improve cultural competency through a cultural consultation model of training in East London, comprising clinical ethnography and assessments of identity, explanatory models, psychosocial factors and therapeutics.⁴⁰ Creating less crisis-orientated spaces in which to consider relevant factors and appreciate the power of institutional forces may offer more opportunities for critical thinking and resistance to group, institutional and legal pressures.^{40 41}

MHA assessments may be psychologically traumatic for the carers and practitioners who may show signs of hypervigilance, desensitisation, disillusionment and distrust that might add to poorer communication, exhaustion, fear of adverse consequences and disempowerment.⁴² All of these can increase defensive practice and risk perceptions, ironically, at a time when a patient is likely to be terrified and feel entirely powerless. Escalation to involve the police rather than apply a preventive intervention already signals a lack of therapeutic connections and speaks to the historical and ongoing power of institutions to criminalise. The interplay of power and poverty and long-standing epistemic injustice continues to face people with mental illness due to the stigma and negation of their views on the grounds that they do not have insight. Professionals too expressed a sense of not being heard nor being able to speak up.

Some argue mental health legislation and coercive care are incompatible with human rights and the interests of those living with disabilities.⁴³ Previous legislative reviews claimed the MHA (England and Wales) appears to violate the UN Convention on the Rights of Persons with Disabilities, for example, Article 4 ('no discrimination of any kind on the basis of disability'), Article 12 (persons shall 'enjoy legal capacity on an equal basis with others in all aspects of life') and Article 14 ('the existence of a disability shall in no case justify a deprivation of liberty').⁴⁴ However, the realities of daily practice are that legislation is required in instances to protect against harm to the individual or others, but its application requires more precise and contextualised judgements and a broader range of options and alternatives to admission. We also need to keep in mind the habitus—cultural nexus—grounded in traditions of practice and history that resist change.

CONCLUSIONS

We evidence new mechanisms by which ethnic inequalities of CAT take place and how this might be prevented. We propose that health systems must ensure sufficient capacity and continuity of care, the required range of specialist services so early and preventive intervention is the norm and alternatives to CAT. New legislation is likely to be optimally effective only if these

conditions are met. Advanced agreements and advocacy seem especially relevant and potentially helpful as an opportunity to prevent or critically plan for preferred care options in future crises. A notable finding is that police involvement was not always necessary but did add to fear and stigma, and clarity is needed on their future role given the history of racism and police interactions and concerns about how mental health services are perceived if there is a reliance on the police. Professional perspectives and demoralisation signal a failure of the system and conflict with professional values. Unless there is widespread service and systems reform, it is likely MHA will continue to be used as a default when other parts of the system do not operate well. A legislative tool to tackle inequalities is not ideal for the patient or the professional.

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Contributors KB conceived the study. KB and RM are guarantors. KB and RM secured funding as joint lead applicants, along with investigators RM, DJ and PM. KN, FK, NH and RR provided additional methodological guidance and support and joined as investigators. KB and RM drafted the paper; all authors reviewed consecutive drafts and contributed to the delivery of the study, interpretation and writing.

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