BENCHMARK

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Reforming the UK's Mental Health Act: Policy Issues and Ethnic Inequalities

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Abstract: Racial and ethnic minority (REM) groups have an increased risk of involuntary psychiatric care. This article critically examines the proposals for addressing these disparities put forward in the 2021 UK governmental white paper, 'Reforming the Mental Health Act'. The policy is evaluated in the context of patient experience. Quality drivers and barriers and enablers that will affect the efficacy of the proposals are analysed. Stigma, structural racism and socio-economic disadvantage are identified as potential drivers of inequality. Data reveals significant heterogeneity between different ethnic groups for indicators of coercive psychiatry, therefore, a single approach for tackling inequality is insufficient. This article also considers whether an attempt to reduce inequalities in detention levels could have the unintended consequence of increasing risk to the public and the ethical dilemmas arising from the need to balance unethical discrimination with public safety.

Keywords: mental health policy, mental health inequality, ethnicity, transcultural psychiatry, coercion

Involuntary psychiatric treatment in England and Wales is legislated for under the Mental Health Act (1983). The rationale for coercion is that mental disorders can compromise rationality to the extent that individuals cannot make genuine autonomous choices (Strickland, Luke & Redekop, 2019). There remains, however, concern about the enactment of the law — particularly over-use of detention and restrictive practices, disregard for patients' views (Akther et al., 2019; Laing, 2022) and the disproportionate use of involuntary treatment for people from racial and ethnic minority [REM] groups (Gupta, Dinakaran & Athanas, 2021; Department of Health, 2024). It has been argued that this leads to avoidable psychological and social harm to REM groups. For many years, there have been calls for improvements to be made to end this unethical racial injustice, yet statistics show that little progress has been made in tackling these inequalities (Ogbeiwi et al., 2024).

In response, the government proposed that new legislation should replace the 1983 Mental

Health Act [MHA]. Following consultation, the white paper 'Reforming the Mental Act' was published by the UK Government in 2021. Although the previous Conservative government did not progress this legislatively, the incoming Labour government has committed to taking reforms forward with the aim of strengthening patient autonomy, raising the threshold for detention and reducing inequalities (Labour, 2024). The MHA is a key statute guiding all mental health practice and this article considers how effective these proposals may be and the ethical dilemmas that arise from the tension between reducing inequality and preserving public safety.

Ethnic inequalities in patient experience.

The 2021 white paper seeks to tackle ethnic inequalities and improve patient experience for REM groups who are more likely to have poorer outcomes, greater difficulty accessing services and report negative experiences when using services (Alam, O'Halloran & Fowke, 2024; Miller, E., Bosun-Arjie, S. F., & Ekpenyong, 2021). The white paper contains a section detailing REM groups' experiences of mental health services where the inequalities are particularly stark for black Caribbean and black African patients. Referencing data from NHS Digital (2020), the paper highlights that black British people are over four times more likely to be detained under the MHA and over ten times more likely to be subject to a community treatment order [CTO]. Additionally, this group are three times more likely to be restrained than white groups (NHS Digital, 2021). As highlighted in a systematic review by Douglas, Donohue & Morrissey (2022), restraint is one of the most negative and often traumatic experiences for inpatients. The care pathway also differs with black groups much more likely to enter services via the criminal justice system as mistrust of services makes these individuals less likely to access support before a crisis point (UK Government, 2021). Phenomenological qualitative research also highlights negative patient experiences across all REM groups (Devonport et al., 2023). Examples include British South Asians with first-episode psychosis who describe Islamophobia and prejudice, stigmatisation of mental illness among their own community and unrecognised aspects of their situation by services (Vyas, Wood & McPherson, 2021). Another study for adults seeking help for depression found services were more disempowering for black Caribbean people, compounding their sense of alienation (Bailey & Tribe, 2021). Running through the narratives in qualitative research is racial discrimination, coercion, mistrust, prejudice, distinct cultural understandings of mental illness and disempowering services all intersecting with one another.

The white paper's policies include various measures to improve REM experience. These

policies include a new patient and carer equality framework which aims to support service providers in their engagement of ethnic minority groups, culturally sensitive advocacy, increasing workforce diversity and numbers of REM staff in leadership positions (UK government, 2021). The NHS Race & Health Observatory (2001) was established to proactively address ethnic inequalities across health and social care settings. Evidence from the body of research supports the paper's claim that these measures will help to address inequality (Bhui, Halvorsrud & Nazroo, 2018; Ross et al., 2020). However, given the complicated nature of health drivers, this, in itself, is not a guarantee of meaningful change.

Health drivers

Health drivers for REM groups are multi-faceted and complex (Rogers & Pilgrim, 2021). Structural racism extends beyond societal attitudes and direct discrimination. REM groups both locally and nationally experience higher levels of unemployment and poverty, and poor housing. These markers of deprivation are all positively correlated with poorer mental health and outcomes (Oliveros, Agulló-Tomás & Márquez-Álvarez, 2022; Silva Ribeiro et al., 2017). Additionally, the impact of the COVID-19 pandemic on mental health has differed between ethnic groups (Proto & Quintana-Domeque, 2021) as has the current cost-of-living crisis (Edmiston, Begum & Kataria, 2022). Evidence suggests that most social problems have a disproportionate negative impact on REM groups. This compounds the inequality experienced by people with mental health conditions who are already among the most socially excluded groups in society. Mental health conditions are influenced by the social environment, which in turn shapes the social and cultural responses to the people who experience them (Boardman, Killaspy & Mezey, 2022).

Ethnicity and mental health: what does the data show?

Evidence shows that REM groups are far more likely to be detained, be subject to restrictive practices on inpatient wards, enter services via the criminal justice system and be subject to a CTO (NHS Digital, 2024; Department of Health, 2024). The most recent data from NHS digital show that rates of detention under the MHA vary widely for different ethnic groups. The ethnic groups with the lowest detention rates are Chinese (52 per 100,000) followed by Indian (55 per 100,000) This is lower than the rate for white British people (63 per 100,000); however, other South Asian groups experience rates higher than white British people (113 and 114 per 100,000 for Pakistanis and Bangladeshis

respectively). The highest rate is among the 'black other' group at 715 detentions per 100,000 (NHS Digital, 2024).

To understand this, it is necessary to look at additional factors such as patterns of immigration, education and income as well as deprivation. Data shows that British Indians are more likely to have higher socio-economic status than British Pakistanis and Bangladeshis but this is not a significant gap (Li, 2018). Education could be a factor. Whilst Chinese men have 35 percent higher educational attainment points than white men, they have a 7-point lower salariat occupation (Li, 2018). Additionally, educational attainment is often higher for some black groups and yet deprivation is similar to that experienced by Asians. Although black Caribbeans have historically had the highest detention rates (Barnett et al., 2019), in 2020/21 black Africans just overtook this group (NHS Digital, 2021).

Data shows the ethnic inequalities in use of restrictive practices such as physical restraint, rapid tranquilization, and seclusion closely mirrors that of headline detention statistics (NHS digital, 2024), consequently there may be common factors driving this inequality. REM groups are 40% more likely to enter via the criminal justice system and in 2019/2020, black groups were ten times more likely to be under a CTO with 61.3 uses per 100,000 people, compared to 6 uses per 100,000 in the white population (NHS Digital, 2021). The latest statistics for 2022/23 show that for white groups the figure is unchanged at 6 uses per 100,00 people but has decreased to 48.8 per 100,000 for black groups (NHS Digital, 2024). Whilst this reduction in inequality is welcome, black Britons are still more than 8 times more likely to be subject to a CTO than their white counterparts. As Carter (2021) explains in her collation of professional opinions, the expert view is that the new white paper aimed at reform is unlikely to address these inequalities and targets such as reducing CTOs are likely to lead to discrimination changing form and showing up elsewhere.

Tackling ethnic discrimination in psychiatric care

The governmental white paper aims to tackle ethnic disparities in mental health, particularly involuntary detention, restrictive practices, and use of CTOs (UK Government, 2021). However, new legislation or policies do not in themselves provide improvements in clinical care or resources. The annual reports of the Care Quality Commission highlight systemic failures to adhere to legislation and policy as it currently stands (Care Quality Commission, 2024a). NHS Trusts and other service providers must have the resources and organisational cultures to effectively implement policy. Whilst

the last government committed mental health services to grow faster than the overall NHS budget (NHS England, 2019), financial resources alone may not be sufficient to address issues such as staff shortages and cultures of constraint and managing risk (Care Quality Commission, 2024a). Whilst targeted, culturally sensitive services are feasible and can improve engagement and mental health outcomes, there is a shortage of practitioners trained in specialist therapies and a lack of cultural competency among staff (Bansal et al., 2022; Vahdaninia et al., 2020). There is, therefore, a real need for services to be genuinely person-centred so nurses ensure that their assessments and care plans truly reflect cultural backgrounds, life history and current circumstances (Healey et al., 2017). Again, resources are the main barrier to implementing this with real-term NHS spending reducing significantly since 2010 (The King's Fund, 2024).

Another limitation of the white paper is that the proposals are significantly contextualised to health and social services without significant consideration of wider social and cultural structures and resources which could usefully be co-opted into a holistic, interprofessional strategy. For example, a systematic review by Devonport et al. (2023) shows that black Africans especially tend to seek help from community leaders rather than health professionals, which increases the likelihood of entering services at the point of crisis, elevating the risk of detention. Working with community leaders to promote timely referrals could help address this issue. Additionally, research by Codjoe et al. (2021) shows that collaboration with black faith communities can help address inequalities but strengthening ties with these organisations is absent from the white paper.

Ethical tensions in psychiatric care and outcomes for REM groups.

Ethnic inequalities in mental health detention and coercive practices have been attributed to structural racism and wider societal attitudes (Carter, 2021; Razai, Majeed & Esmail, 2021). These, however, are not the only explanations. Other explanations include higher prevalence of psychosis in these groups (Barnett et al., 2019). The higher prevalence itself may also be due to these attitudes and structural racism and the fact that higher prevalence in REM groups is contextual - the rates of serious mental illness are much lower for these groups in their native countries where they are comparable to prevalence in white populations in Western countries (Jongsma et al., 2021). Similarly, the higher prevalence of CTO's may be due to lower levels of voluntary engagement in treatment and the barriers created by lack of cultural competency in services as previously discussed. Whilst there may be racial bias in risk assessments for individuals with mental disorders, a blunt target driven

approach to reducing detentions for REM groups risks allowing a higher threshold of risk for these service-users than their white counterparts before detaining them to protect themselves and others (Day, Woldgabreal & Butcher, 2022.). This ideological target driven approach could create an unacceptable risk.

There are two potential types of harm that can arise from untreated mental illness, harm to self and harm to others. Considering first harm to others, in the United Kingdom over 100 people are murdered every year by a person with a serious mental illness (Farrell, 2021). Several recent high-profile attacks carried out randomly against members of the public have again bought this issue into focus (Butler, 2024). As highlighted by advocacy groups and charities, violent crimes by persons with a mental disorder are rare and they are more likely to be victims of violence than perpetrators (Thornicroft, 2020). Nonetheless, people with a serious mental illness have an increased risk of violence and there are proven links between violence and mental disorders (Whiting, Lichtenstein & Fazel, 2021). It is noteworthy that whilst in the USA there are high-profile voices highlighting this risk and the need for involuntary treatment, most notably Edwin Fuller Torrey and his Treatment Advocacy Center (Geller & Norian, 2022), this voice is almost entirely absent in the UK. Aside from the voices of victims' families such as the charity Hundred Families (Hendy, 2016), the professional space is dominated by voices advocating for least restrictive practice.

One such recent high-profile case in the UK involved a man named Valdo Calocane who stabbed three strangers to death in Birmingham in 2023. At the time of the attack, he was not taking medication and had been out of touch with mental health services for over a year and showed little insight into his mental health condition (Care Quality Commission, 2024b). This case was referenced when the UK health secretary recently met with the father of one of the victims and as a result promised to 'slow down' reforms of the MHA highlighting the need to get:

> *"…the balance right between recognizing there are people whose liberties are being deprived today who could live safely in the community, but also recognizing for others there needs to be much better and closer supervision so that people like Calocane are not able to be on the street causing risk or fatalities to others"* (Murray, 2024).

This balancing will likely prove challenging to policy makers. In relation to ethnic inequalities, the perpetrators of both the recent Nottingham and Birmingham attacks were from black minority

groups. If REM groups have higher prevalence of mental illness, then the only way of reducing inequalities whist preserving public safety is to address the root causes of this higher prevalence such as poor housing, poor employment and educational opportunities, poverty and structural racism whist investing in services including culturally targeted interventions and culturally sensitive services. Given the current parlous state of UK finances and the government themselves highlighting the need for difficult and painful spending decisions, this looks unlikely to happen within the next few years at least.

Considering potential harm to self, this is an area more ethically fraught. Even the most libertarian thinker who holds that autonomy should be the ruling principle of medical ethics will pay heed to the harm principle that essentially posits that it is only ethical to infringe on an individual to prevent harm to others (Chakraborti, 2023). However, many detentions under the MHA are to prevent harm to self, and here the ethical case for coercion is less clear. One of the arguments for allowing the medical principle of beneficence (the requirement for healthcare professionals to act in the best interests of their patients) to override autonomy (the right to self-determination) is that rationality is a prerequisite of genuine autonomy (Pugh, 2020).

Patients with serious mental illness have their rationality compromised by the illness itself but an examination of the mental states and nuances found in psychiatric patients show that this loss of rationality is not always evident, and it has been posited that suicide, even in serious mental illness, can sometimes be rational (Hewitt, 2010; Grigoriou, Upthegrove, & Bortolotti, 2019).

Yet even if it is more ethically justified to allow autonomy where it may result in harm to self and not others, it can be argued that this could compound ethnic inequalities. If REM groups are more likely to suffer from serious mental illness, poverty and other disadvantages, then they will be more likely to complete suicide or attempt suicide. Simply allowing this in the name of autonomy could be seen as a driver of inequality and poor outcomes for REM groups by not intervening to prevent the worst possible outcome.

Conclusions and recommendations

This article highlights that REM groups are more likely to experience coercive psychiatry, including detention and being subject to a CTO, and the statistics vary widely between different ethnic groups indicating that the drivers of inequalities are complex and multi-faceted. Coercion leads to poor patient experiences characterised by mistrust of services often compounded by wider societal

attitudes and discrimination. The policy, '*Reforming the Mental Health Act*' makes recommendations that are well grounded in evidence such as having culturally sensitive services, a more diverse workforce and better training. However, the policy also risks failing to tackle inequality due to its failure to consider the social inequalities and wider discrimination that drives inequality. One risk is that contextualising reform to health and social services rather than broader macro environments misses the opportunity to draw on the existing strengths of REM communities. A recommendation is that the white paper policy driver is enhanced in relation to early intervention for groups at higher risk of detention. This should be achieved by undertaking outreach collaboratively. Health and social care organisations should work with faith groups, community organisations, youth organisations, food banks and other spaces where REM groups at risk of mental health crises may make connections with people they trust. The author of this article recommends more culturally specific research studies to support this. REM groups need to be treated in a non-discriminatory way but not in a manner that would increase the risk of harm to self, family and the public. Reducing inequality should address the underlying causal factors. There is a risk that a target driven approach will not only fail to achieve this but could increase the risk of harm.

References

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open, 5*(3), e37. 10.1192/bjo.2019.19

Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *Cognitive Behaviour Therapist, 1*710.1017/S1754470X24000084

Bailey, N. V., & Tribe, R. (2021). A qualitative study to explore the help-seeking views relating to depression among older Black Caribbean adults living in the UK. *International Review of Psychiatry, 33*(1-2), 113–118. 10.1080/09540261.2020.1761138

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLoS Medicine, 19*(12), e1004139. 10.1371/journal.pmed.1004139

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

Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: ethnic inequality and severe mental illness. *British Journal of Psychiatry, 213*(4), 574–578. 10.1192/bjp.2018.148

Boardman, J. (2022). *Social Inclusion and Mental Health* (Second edition ed.). Cambridge University Press. 10.1017/9781911623601

Butler, P. (2024). String of killings have put spotlight on adequacy of mental health care in UK. *The Guardian (London)* https://www.theguardian.com/society/2024/apr/30/killings-adequacy-of-mental-health-care-nhs

Care Quality Commission. (2024a). *Monitoring the Mental Health Act in 2022/2023.* Retrieved October 10th, 2024, from https://www.cqc.org.uk/publications/monitoring-mental-health-act/2022-2023

Care Quality Commission. (2024b). *Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2.* Retrieved October 22nd, 2024, from https://www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review-part2

Carter, C. (2021). *Mental Health Act overhaul will not tackle racial disparities without societal change, experts warn. Community Care, 20 Jan.* Retrieved October 22nd, 2024, from https://www.communitycare.co.uk/2021/01/20/mental-health-act-overhaul-will-tackle-racial-disparities-without-societal-change-experts-warn/

Chakraborti, C. (2023). *Introduction to Ethics : Concepts, Theories, and Contemporary Issues* (1st ed.). Springer Nature Singapore. 10.1007/978-981-99-0707-6

Codjoe, L., Barber, S., Ahuja, S., Thornicroft, G., Henderson, C., Lempp, H., & N'Danga-Koroma, J. (2021). Evidence for interventions to promote mental health and reduce stigma in Black faith communities: systematic review. *Social Psychiatry and Psychiatric Epidemiology, 56*(6), 895–911. 10.1007/s00127-021-02068-y

Day, A., Woldgabreal, Y., & Butcher, L. (2023). Cultural Bias in Forensic Assessment: Considerations and Suggestions. *Challenging Bias in Forensic Psychological Assessment and Testing* (1st ed., pp. 245–258). Routledge. 10.4324/9781003230977-16

Department of Health. (2024). *Ethnicity Facts and Figures: Detentions under the Mental Health Act.* Retrieved October 24th, 2024, from https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/#

Devonport, T. J., Ward, G., Morrissey, H., Burt, C., Harris, J., Burt, S., Patel, R., Manning, R., Paredes, R., & Nicholls, W. (2023). A Systematic Review of Inequalities in the Mental Health Experiences of Black African, Black Caribbean and Black-mixed UK Populations: Implications for Action. *Journal of Racial and Ethnic Health Disparities, 10*(4), 1669–1681. 10.1007/s40615-022-01352-0

Douglas, L., Donohue, G., & Morrissey, J. (2022). Patient Experience of Physical Restraint in the Acute Setting: A Systematic Review of the Qualitative Research Evidence. *Issues in Mental Health Nursing, 43*(5), 473–481. 10.1080/01612840.2021.1978597

Edmiston, D., Begum, S., & Kataria, M. (2022). *Falling Faster amidst a Cost-of-Living Crisis: Poverty, Inequality and Ethnicity in the UK*. Runnymede Trust.

Farrell, M. (2021). *Homicide and Severe Mental Disorder* (1st ed.). Taylor & Francis.

10.4324/9781003172727

Geller, J., & Norian, I. (2022). Advocacy in Evolution: The Push and Pull of Psychiatrists. *Textbook of Community Psychiatry* (pp. 51–72). Springer International Publishing. 10.1007/978-3-031-10239-4_6

Grigoriou, M., Upthegrove, R., & Bortolotti, L. (2019). Instrumental rationality and suicide in schizophrenia: a case for rational suicide? *Journal of Medical Ethics, 45*(12), 802–805. 10.1136/medethics-2019-105454

Gupta, S., Dinakaran, D., & Athanas, E.Mental Health of Black and Minority Ethnic Communities in the UK and the Utilization of the Mental Health Legislation. *Mental Health, Mental Illness and Migration* (pp. 513–522). Springer Singapore. 10.1007/978-981-10-2366-8_30

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: a systematic review. *BMC Health Services Research, 17*(1), 8. 10.1186/s12913-016-1953-x

Hendy, J. (2016). *Why did you kill my dad?* Retrieved October 20th, 2024, from https://www.hundredfamilies.org/about/

Hewitt, J. (2010). Rational suicide: philosophical perspectives on schizophrenia. *Medicine, Health Care, and Philosophy, 13*(1), 25–31. 10.1007/s11019-009-9183-1

Jongsma, H. E., Karlsen, S., Kirkbride, J. B., & Jones, P. B. (2021). Understanding the excess psychosis risk in ethnic minorities: the impact of structure and identity. *Social Psychiatry and Psychiatric Epidemiology, 56*(11), 1913–1921. 10.1007/s00127-021-02042-8

Labour. (2024). *Labour Manifesto: Build an NHS fit for the future .* Retrieved October 24th, 2024, from https://labour.org.uk/change/build-an-nhs-fit-for-the-future/

Laing, J. (2022). Reforming the Mental Health Act: Will More Rights Lead to Fewer Wrongs? *Medical Law Review, 30*(1), 158–176. 10.1093/medlaw/fwab041

Li, Y. (2018). Integration Journey: The Social Mobility Trajectory of Ethnic Minority Groups in Britain. *Social Inclusion, 6*(3), 270–281. 10.17645/si.v6i3.1542

Miller, E., Bosun-Arjie, S. F., & Ekpenyong, M. S. (2021). Black and ethnic minority carers perceptions on mental health services and support in the United Kingdom: a systematic review. *Journal of Public Mental Health, 20*(4), 298–311. 10.1108/JPMH-12-2020-0152

Murray, J. (2024). *Ministers to 'slow down' mental health changes after Valdo Calocane report*. Retrieved October 7th, 2024, from https://www.theguardian.com/society/article/2024/aug/13/mental-health-care-reforms-slowed-down-valdo-calocane-nottingham-attacks

NHS Digital. (2020). *Mental Health Act Statistics, Annual Figures 2019-20.* Retrieved October 24th, 2024, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures

NHS Digital. (2021). *Mental Health Act Statistics, Annual Figures 2020/21.* Retrieved October 24th, 2024, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-

statistics-annual-figures/2020-21-annual-figures

NHS Digital. (2024). *Mental Health Act Statistics, Annual Figures 2022/23.* Retrieved October 24th, 2024, from https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2022-23-annual-figures#highlights

NHS England. (2019). *NHS Mental Health Implementation Plan 2019/20 – 2023/24 .* Retrieved October 7th, 2024, from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

NHS Health & Race Observatory. (2021, *Driving Race Equity In Health and Care: Strategy 2021 – 2024.* Retrieved October 24th, 2024, from https://www.nhsrho.org/about-us/our-strategy/

Oliveros, B., Agulló-Tomás, E., & Márquez-Álvarez, L. (2022). Risk and Protective Factors of Mental Health Conditions: Impact of Employment, Deprivation and Social Relationships. *International Journal of Environmental Research and Public Health, 19*(11), 6781. 10.3390/ijerph19116781

Proto, E., & Quintana-Domeque, C. (2021). COVID-19 and mental health deterioration by ethnicity and gender in the UK. *Plos One, 16*(1), e0–e0244419. 10.1371/journal.pone.0244419

Pugh, J. (2020). *Autonomy, rationality, and contemporary bioethics* (1st ed.). Oxford University Press.

Razai, M. S., Majeed, A., & Esmail, A. (2021). Structural racism is a fundamental cause and driver of ethnic disparities in health. *BMJ, 373*, n938. 10.1136/bmj.n938

Rogers, A., & Pilgrim, D. (2005). *Sociology of Mental Health and Illness* (1st ed.). McGraw-Hill Education.

Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M., & Dahir, S. (2020). *Workforce race inequalities and inclusion in NHS providers*. The King's Fund.

Silva Ribeiro, W., Bauer, A., Andrade, M. C. R., York-Smith, M., Pan, P. M., Pingani, L., Knapp, M., Coutinho, E. S. F., & Evans-Lacko, S. (2017). Income inequality and mental illness-related morbidity and resilience: a systematic review and meta-analysis. *The Lancet Psychiatry*, 4 (7). pp. 554-562. ISSN 2215-0366

Strickland, N., Luke, C., & Redekop, F. (2020). When People Lose Autonomy: The Case for Coercion and the Moral Responsibility Crisis Clinicians Have to Society. *International Journal on Responsibility, 3*(2)10.62365/2576-0955.1032

The King's Fund. (2024). *The NHS budget and how it has changed.* Retrieved October 24th, 2024, from https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell

Thornicroft, G. (2020). People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach. *The Lancet. Public Health, 5*(2), e72–e73. 10.1016/S2468-2667(20)30002-5

UK Government. (2021). *Reforming the Mental Health Act.* Retrieved October 24th, 2024, from: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951398/mental-health-act-white-paper-web-accessible.pdf*

Vyas, A., Wood, L., & McPherson, S. (2021). A qualitative exploration of stigma experiences of

second-generation British South-Asian people using an early intervention in psychosis service. *Psychosis, 13*(4), 302–314. 10.1080/17522439.2021.1897654

Whiting, D., Lichtenstein, P., & Fazel, S. (2021). Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment. *The Lancet. Psychiatry, 8*(2), 150–161. 10.1016/S2215-0366(20)30262-5

Competing interests: none
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Publication Date: June 20, 2025