



Mental Health Alliance

Briefing for the Second Reading of the Mental Health Bill in the House of Lords

Black and Minority Ethnic Mental Health Service Users

The Government's own statistics highlight staggering ethnic inequalities in the use of mental health services.¹ Overall, inpatients from the Black Caribbean, Black African, and Other Black groups are 33-44% times more likely to be detained under the Mental Health Act 1983 when compared with the average for all inpatients.² The rate of detention for inpatients from the Other White group was also slightly higher than average. Differences among other minority ethnic groups were not statistically significant.

There is a history of misunderstanding and discrimination when it comes to the use of compulsory power, which has resulted in the deaths of a number of African Caribbean service users while under the care of the mental health system, tragically highlighted by the death of David Bennett. It is also well documented that African Caribbean service users are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage.³ Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression.⁴

The Alliance is committed to preventing this from happening in the future and we are concerned that the Mental Health Act 1983, unless radically amended, will continue to disadvantage African Caribbean and other BME communities who use mental health services. In this we share the concerns expressed by organisations such as the BME Mental Health Network, Songhai, the Transcultural Psychiatry Society and the African and Caribbean Mental Health Commission.

The Alliance considers it a top priority to ensure that changes are made to the 1983 Act which tackle discrimination and actively promote race equality. The Government has published the results of a Race Equality Impact Assessment on its proposals for reform, but has failed to respond to its recommendations in the drafting of this Bill. The Alliance is calling in particular for the following amendments to the 1983 Act.

Principles on the face of the 1983 Act

Principles of non-discrimination and respect for diversity should be on the face of the Bill. As in the Scottish mental health (Care and Treatment) Act these should be principles to which practitioners 'must have regard'.

Respect for diversity

Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

¹ Count me in: The National Mental Health and Ethnicity Census 2005 Service User Survey: MHAC

² *ibid.*

³ Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear

⁴ Report into the Death of David Bennett (2003)

Equality

All powers under the act, particularly those relating to access to services, assessments and the provision of services shall be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion, or national, ethnic or social origin.

The importance of the role of principles in giving the Black and Minority Ethnic community's confidence in the professionals who exercise powers under the Act can not be overestimated. Setting the values which should govern practice under the Act on the face of the statute will also assist professionals in their practice – and notably is strongly advocated by the professional organisations themselves. It is visible recognition by Parliament of the need to overcome stigma and discrimination. It will assist the development of a culture of respect for the qualities, abilities and diverse backgrounds of individuals and equally, a need to avoid making general assumptions on the basis of ethnic, cultural and religious stereotypes. Crucially, it will also guide the development of future case law by establishing parameters for judicial interpretations of the Act. This will enshrine race equality with all future developments of the legislation.

Definition of 'mental disorder', exclusions and conditions

The cumulative effect of the Mental Health Bill is to enlarge the net and to increase the number of people potentially subject to compulsion - particularly in the community. In circumstances in which people from BME communities already experience discrimination, however unintentional, the disproportionate impact this enlargement will have on these communities cannot be discounted. It may be particularly noticeable in the exercise of criminal justice powers. The positive duty to promote equality therefore requires specific provisions to address this danger.

(i) 'a person shall not be considered to have a mental disorder by reason only of cultural beliefs or behaviour.'

In a multicultural society there is diversity in the understanding of concepts such as 'mind' and 'mental disorder' and a danger that a person's behaviour may be misconstrued. Extensive literature confirms that racism (racial discrimination maintained by established power/authority) can apply in the practice under the current law – and is even more likely under the broader definition of mental disorder. An exclusion such as this is necessary to delimit the operation of the definition. The Joint Scrutiny Committee agreed:

'Although we would wish that specific exclusions of this kind were unnecessary, we note that some cultural minorities are greatly over-represented among patients treated under compulsion. Without making any judgments as to the complex reasons for this, we think an important signal value would be achieved by setting out a specific exclusion of the use of compulsion solely on the basis of behaviour exclusively and directly attributable to cultural or indeed political beliefs. We understand religious beliefs to be part of cultural beliefs, and therefore we do not feel that it is necessary to state religious beliefs separately.'

(ii) Appropriate treatment

The Government proposes to remove the treatability test from the 1983 Act and introduce a provision that any treatment will simply have to be 'appropriate' for the patient and 'available' to him/her.

Under current law there needs to be a direct health benefit to all patients on renewal of a section and to some patients at the outset of a section 3 order. The concept of 'appropriate treatment' 'in all the circumstances of the case' even if further defined in a Code of practice is not sufficiently precise. Wherever wider discretion is introduced, there is a risk that biases/ prejudices already existing in practice will persist, and tighter wording is needed to be in place to prevent this. If treatment is to be appropriate it needs to be clear that the

patient has a role in the choice of treatment and a duty to consult an advance statement should be part of that.

(iii) Community treatment orders

The Bill states that community treatment orders can only be issued where services are available in the community. The Code of practice should specify that these services must be culturally appropriate.

The breadth of the powers of community treatment orders give rise to concern given their potential to be used to keep people who are no longer sufficiently ill to require hospitalisation on medication which they have not chosen to take (otherwise they would not need compulsory powers). For reasons indicated above, this is likely to have a disproportionate impact on BME individuals. It will confirm the perception prevalent within many BME communities that mental health services are intrusive, coercive and a representation of authority which seeks to 'manage' and 'contain' racialised groups labelled as threatening and dangerous. This will reinforce the alienation of BME people from mental health services – in direct contradiction to Delivering Race Equality. We believe that the application of community treatment orders must be narrowed significantly.

Advocacy

The right to advocacy is particularly important in the cases of people from BME communities. BME groups have been shown to be more socially isolated and this isolation affects both their pathway into the compulsory mental health system and health outcomes⁵. Skilled advocates will have a central role in dispelling misunderstandings and preventing confrontations that can lead to inappropriate and unnecessary recourse to compulsory powers. For a frightened and mentally distressed person, who distrusts authority and who may have no one to support him or her, an advocate can make a real difference, particularly at the initial stage when a person unknown to services first presents for admission or is put in a place of safety. The provisions for advocacy in the 2004 Bill should be reproduced in the 1983 Act

Control & Restraint

There is an extensive body of evidence to show that African Caribbeans are more often treated in locked wards and are subject to higher instances of control and restraint. Current safeguards around the use of control and restraint are inadequate in terms of their scope and application.

The enquiry into the death of David Bennett recommended a maximum three-minute time limit on prone restraint⁶. The Joint Parliamentary Scrutiny Committee recommended that regulations on its use should be set out in the Code of Practice, which would stipulate that control and restraint should be:

- used only when absolutely necessary;
- subject to regular monitoring and review;
- an incidence should be brought to an end immediately when the intervention is no longer necessary for the protection of others.
- Reported to the MHAC and if the procedure is prolonged, an expert panel should visit the patient.⁷

⁵ Thornicroft G, Davies S, Leese M: Health Service Research and forensic psychiatry: a black and white case. *International Review of Psychiatry* 1999, 11, 250-257.

⁶ Independent Inquiry into the Death of David Bennett.

⁷ Joint Committee Recommendation 81

The Alliance, together with the Mental Health Act Commission, takes the view that it is insufficient for this issue to be left to be regulated by the Code of Practice. As the Joint Committee on Human Rights stated (at a time in which it was believed that the Code of Practice could not be departed from except in exceptional cases).

“We are not confident that Convention compliance can be effectively and comprehensively ensured without some statutory obligations in this area. This should include statutory obligations on all health authorities to keep comprehensive records of all violent incidents.”

Treatment safeguards

David Bennett was prescribed multiple doses of anti-psychotics – the equivalent of one and a half times the maximum recommended dose. The Mental Health Alliance is calling for a requirement to adhere to the British National Formulary Limits on Medication (other than in exceptional circumstances when further safeguards would apply) and a legal obligation for clinicians to report any breaches to managers to be included in amendments to the 1983 Act.

Places of Safety

The Alliance deprecates the use of police stations as a ‘place of safety’. Despite the Mental Health Act Code of Practice advising that police cells should not generally be used, in practice police cells are used on about 80% of occasions when section 136 powers are evoked.⁸ This is of particular concern from a race equality perspective given the evidence that Section 136 is used disproportionately amongst people from BME communities⁹.

The Joint Committee on Human Rights stated:

‘People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose, and their use for this purpose may lead to breaches of Convention rights. In our view, there should be a statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources for this by the Government.

Ensuring the safety of people detained by the police is not a single agency problem that can be addressed by the police alone. It also involves the responsibilities of health authorities, and requires good co-ordination between health authorities and the police. Transfers from police cells to hospital must operate more effectively. We recommend that a statutory duty be placed on healthcare trusts to take responsibility for people detained under section 136 of the Mental Health Act.”

While the Alliance welcomes additional investment in more appropriate ‘places of safety’, we believe that the 1983 Act should statutory obligations that:

- The place of safety must be a therapeutic environment wherever possible
- Police cells should only be used in exceptional circumstances and for a maximum period of 6 hours (instead of 72 hours as under s.136)
- There should be a duty on Health Authorities to provide places of safety,
- There should be a duty on healthcare trusts to take responsibility for people detained under section 136 of the Mental Health Act.

⁸ Lord Adebowale – Q875 Evidence to the Joint Committee

⁹ [Turner TH](#), [Ness MN](#), [Imison CT](#), Mentally disordered persons found in public places'. Diagnostic and social aspects of police referrals (Section 136). [Psychological Medicine](#), 1992 Aug; 22(3):765-74, Thornicroft et al 1999 op. cit..

Right to move hospital

In line with the recommendation of the Bennett inquiry, families and patients should be made aware that they have a right to ask to move from one hospital to another: applications should be recorded and reasons for refusals given.

Tribunals

Membership of the Mental Health Review Tribunal does not specifically include people from Black and Minority Ethnic and we believe this is crucial to ensure that Tribunals are able to take full account of a person's culture and circumstances, e.g.:

- the degree of involvement with both the culture of origin and the host culture, taking special recognition of language abilities and preferences
- the predominant idioms of distress through which symptoms or the need for social support are committed, e.g. possessing spirit, somatic complaints, inexplicable misfortunes
- culturally relevant interpretations of social stressors, social support, levels of functioning disability
- cultural elements of the relationship between the individual and the clinician and the problems these may cause in diagnosis and treatment.

We therefore recommend that Tribunals should include BME representation where appropriate and that Tribunals should include BME representation where appropriate, and that all Tribunal members are trained in cultural competency.