Mental Health Alliance

Re: REIA consultation, gateway reference 6558

Please find attached the Mental Health Alliance's response to the REIA consultation questionnaire, which provides further detail on our position on race equality and proposals to amend the 1983 Mental Health Act. This letter sets out our policy priorities where they do not fit within the scope of that questionnaire. We would ask that you consider these further comments fully in the analysis of your consultation, as they represent key concerns for the Mental Health Alliance's 77 member organisations.

Background to this submission

British society is multicultural and multiracial and all areas of public policy should reflect the needs of an ethnically diverse population. The Race Relations Amendment Act 2001 was a bold and far sighted response to the awareness that institutional racism persists in our society and needs a stronger legal framework than is provided by antidiscrimination law. Its raison d'etre is to improve outcomes rather than merely processes through the duty on public authorities to promote race equality. That duty operates in two distinct ways, first to identify and overcome entrenched discrimination through positive measures and secondly, as a form of affirmative or positive action, whether or not actual discrimination is shown to exist, to take special measures for the benefit of a disadvantaged group. It is both these aims which provide the rationale for all the MHA proposals for legislative reforms in the name of racial equality.

There is no doubt that racism is an element in the delivery of mental health services under the 1983 Act. Research consistently shows startling disparities in the use of mental health care across racial groups. The 2005 "Count me in" census[1] provides an insight into the true extent of the disparities in inpatient mental health care.

In the 2005 Census of inpatients in mental health hospitals, Black Caribbean, African and Other groups were 33-44% more likely to be detained under the MHA83. These results confirm the findings of a 2003 systematic review of scientific literature which found that, on the basis of existing research, Black people were over 4 times more likely to be admitted under the Mental Health Act. The review found strong evidence for a relative excess of Black admissions to compulsory care, even when age, gender, socio-economic status, and previous service use were controlled for[2].

There is also a history of misunderstanding, discrimination and bad practice when it comes to the practice of using coercive powers against African Caribbeans.[3] At its mildest, this can lead to fear of accessing care and poorer outcomes for patients from BME communities. At its very worst, it can lead to tragedy, including the deaths of a number of African Caribbean service users while under the care of the mental health system, highlighted by the death of David Bennett.

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[1] The national census covered 99% of the population of all mental health hospitals and facilities in England and Wales on one day, the 31st March 2005.

[2] Bhui K, Stansfeld S, Hull S, Priebe S, Mole F and Feder G: Ethnic Variations in pathways to and use of specialist mental health services in the UK: Systematic Review. British Journal of Psychiatry (2003), 182, 105-116.

[3] Sainsbury Centre for Mental Health Breaking the Circles of Fear: a review of the relationship between mental health services and African and Caribbean communities. 2002, SCMH

There are many reasons for the disparities, some of which do not relate to the legislation itself. However, the Alliance believes strongly that to separate legislation from practice is misconceived particularly where the legislation provides a measure of discretion to practitioners or uses terms that involve a large degree of judgment. Fair and equal treatment should, in the context of this legislation, mean that less use of coercive measures for Black people. In general the legislative reform offers a vital opportunity to overcome disadvantage for persons form a BME background who may find themselves subject to compulsion.

Achieving race equality in mental health services

There is a need for an appropriate multi-cultural approach to mental health that aims to create and deliver racially and culturally appropriate mental health services. This approach should be multifaceted and acknowledge the role of institutions, practices and attitudes in producing meaningful changes. The Department of Health has made important steps to this end in its "Delivering Race Equality" programme. To cement these changes within the institutional framework, the Alliance believes there is a need for mental health legislation that reflects and acknowledges 'culture' and 'race', and counteracts institutional racism.[4] In this we share the concerns expressed by experts in the field and other organisations such as the BME Mental Health Network.

Alliance Response to Questionnaire

Amendment one: To introduce a new simplified definition of mental disorder and abolish the four existing categories of mental disorder.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes, and in conjunction with amendments 2 and 3 on appropriate treatment and SCT

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

No

Is there public concern/are you or people you know concerned about the possibility that the proposed amendment could cause discrimination and could damage good race relations?

In conjunction with amendments 2 and 3 -yes

What evidence, if any, have you used to support the conclusions you have reached?

There is evidence of the fact that misdiagnosis of black people has led to their being placed under compulsion for more serious forms of mental disorder. The extensive research on this is documented in evidence by the BME network (DMH 445) and by the African and Caribbean mental Health Commission (DMH 313) given to the Joint Scrutiny Committee. This evidence is attached.

Do you think this evidence is adequate? If not, what other information do you believe is required/ would you have found useful?

The evidence is adequate

Risk of adverse effects on race equality:

[4] Home Office The Stephen Lawrence Inquiry Report, 1999, TSO

Highly likely to have adverse effect on race equality (high risk)

Potential for benefit:

Probably will not promote race equality- Low potential (high risk)

How big is the risk (in terms of both the number of people who could be affected and the severity of the problem)

Lots of people from many racial groups may be affected to some extent

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

The Alliance believes that the principles of equality, non discrimination and respect for diversity should be included, with other principles, on the face of the Bill. The importance of principles to the black and minority community can not be overestimated. It is visible recognition by Parliament of the need for stigma and discrimination to be overcome. It will be a constant reminder for professionals that when taking important decisions under mental health legislation, including applying the definition of mental disorder, there is a need to give respect to 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.

Applying a set of principles to mental health legislation should be part of a wider Government commitment to joined-up thinking across departments to ensure that the Act is linked to other Government initiatives and to anti-discrimination legislation including the Race Relations Amendment Act, the Disability Discrimination Act, the Children Act and the Sex Discrimination Act.

The amendment should include an exclusion clause that mental disorder should not be construed by 'reason only of cultural or religious beliefs and / or behaviours' as was recommended by the Joint Scrutiny Committee

Amendment two: To ensure that detention is only used where it is properly justified but that where it is justified there are no arbitrary restrictions so that people with mental disorder who need compulsory treatment can get it. An appropriate treatment test will be introduced, and the 'treatability' test abolished.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

No

Is there public concern/are you or people you know concerned about the possibility that the proposed amendment could cause discrimination and could damage good race relations?

Yes

Do you have any doubts about any of the above questions?

No

What evidence, if any, have you used to support the conclusions you have reached?

The evidence is both in terms of research and anecdotal evidence from service users, carers and practitioners. This is extensively documented in evidence to the Joint Scrutiny Committee by the BME network at Evidence DMH 445 with addenda by Dr McKenzie and Professor Fernando. This indicates that BME patients are more likely to be perceived as dangerous and as needing high dosages of medication – this will be exacerbated in a situation in which decisions need to be made about 'appropriate treatment' which is clinically not a meaningful term (given particularly the breadth of the definition of treatment).It will undoubtedly lead to more defensive practice in a risk averse environment and to more Black people being detained and remaining detained.

Do you think this evidence is adequate? If not, what other information do you believe is required/ would you have found useful?

No. More evidence of the experience of BME patients (through case studies for instance) would be useful - for instance there is evidence that many voluntary patients feel coerced into complying with treatment for fear of being sectioned if they do not comply. It would be helpful to know whether this is more common among BME patients (and the reasons for it) as this could have a bearing on how the appropriate treatment test will work. The workings of the current treatability test both under s.3 and s 20 would also be useful. It is impossible to answer question 3 with any accuracy.

Risk of adverse effects on race equality:

Highly likely to have adverse effect on race equality (High risk)

Potential for benefit:

Probably will not promote race equality - Low potential (high risk)

How big is the risk (in terms of both the number of people who could be affected and the severity of the problem)

Not enough information to know.

If the amendment was fairly applied to all racial groups and promoted equality of opportunity and good race relations what would we see (and what would people experience)?

It is not possible to take measures to ensure that this will be fairly applied as the law itself needs to change to provide for the need that the patient receives a therapeutic benefit from the treatment. The law itself is likely to have a discriminatory impact.

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

It is vital that the law makes clear that there must be a health benefit for the patient in order for him/her to be detained. Under current law this applies to all patients on renewal of a section and to some patients at the outset of a s3 order. The term 'in all the circumstances of the case' even if backed up by a Code of Practice is also too broad to prevent discriminatory practices and could be replaced with more specific wording that acknowledges race and culture.

Amendment three: To introduce supervised community treatment (SCT) for patients after a period of detention in hospital. This will allow some people who would otherwise be in hospital to live in the community under the powers of the Mental Health Act, to ensure they continue with medical treatment.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

No

Is there public concern/are you or people you know concerned about the possibility that the proposed amendment could cause discrimination and could damage good race relations?

Yes

What evidence, if any, have you used to support the conclusions you have reached?

While some members of the Alliance are opposed to any form of compulsory treatment in the community, given the Government's commitment to introducing it we accept it is necessary to consider how it will be introduced in a constructive manner and with appropriate safeguards. The Alliance does not agree that SCT should be introduced unless the conditions for compulsion include greater limits than are proposed. Furthermore if SCT is to be introduced as the Government intends, it should only be imposed on a clearly defined and clinically identifiable group of patients - and the scope and potential duration of SCT should be limited. Much of the opposition to CSTs arises because of its likely impact on BME groups

Evidence on the use of community treatment orders from the US and Canada has shown that typically, patients placed on the orders are male, less than 40yrs old, and non-white, with a diagnosis of schizophrenia. It is likely that this indicates a higher level of coercion imposed on this community. It appears that the new provisions for SCT will fit into the scheme of the 1983 Act by expanding the grounds for compulsion not as a form of leave from s.3. If so the potential for all those under CSTs – disproportionately black males - to remain on them is increased. So the level of the use of coercion against the BME patients will rise. This is most disturbing.

A review of the evidence on CTOs (Kisely et al 2005) has shown that they are likely to increase levels of patient's perceived coercion. Perceived coercion is already high in BME communities (Breaking the Circles of Fear), and the negative perception this gives of mental health services keeps people away from services. Any additional measure of coercion can only harm the relationship between BME groups and MH services.

We sympathise with the views expressed by Dr Kwame McKenzie (responding to proposals in the 2004 Draft Bill):
'who will have one of these community treatment orders? Clearly people who are not ill enough to be in hospital, people who see things differently from their psychiatrist, people who have a different culture and belief on their treatment than their psychiatrist, people who are not satisfied with their treatment and want an alternative. Research shows us that people from minority groups in the system are more likely to fit this description. Because of

this you will be more likely to be on an NRO if you are from a black and ethnic minority group.'

In terms of how decisions are made in relation to the application of SCT, the Department of Health briefing on SCT states that: "Decisions as to whether a patient should be subject to SCT will be based on a clinical judgement of the person's condition and circumstances. "

The Alliance is concerned that the discretion which is left to supervising clinicians in determining who should be placed on an order for supervised community treatment will allow SCT to be subject to the same biases and prejudices found elsewhere in the system.

The Alliance believes that criteria for compulsion under SCT should overtly state the need for consideration of a person's cultural and racial background.

If SCT is used as a preventive measure to reduce the risk of relapse and subsequent future harm to self or others, we are also concerned that SCT might affect BME groups disproportionately because clinicians associate Black people with non-compliance and greater risk. In 1993 there was a major inquiry into the death of three Black men at Broadmoor Hospital, which highlighted the perception of those delivering health care in the mental health system about race as an index of dangerousness. In 2003, the report of the inquiry into the death of David Bennett made similar comments. The AESOP study into ethnicity and psychosis found that in a cohort of patients with first onset psychosis, the main difference between ethnic groups admitted to inpatient care was the reason given for detention: African Caribbean patients were significantly more likely to be admitted because of a violent incident or perceived as threatening by others

The Alliance supports the concerns expressed by the National Black and Minority Ethnic Mental Health Network: "emphasis on the perceived risk to the public chimes with popularly held stereotypes of 'threat' and 'dangerousness' applied to mental health service users, particularly those from BME communities….The potential for risk assessments to be influenced by stereotypes of 'dangerousness', particularly where African-Caribbean men are concerned makes this provision worrying."

The Alliance believes that the condition stating that SCT can only be prescribed where services are available in the community should specify that these services must be culturally appropriate. We support the BME Network recommendation to include an amendment that makes it legally binding for detaining authority to consult with such persons, community organisations and human rights bodies that have knowledge of patient's social and cultural background.

There is little information given to date about the conditions which can be placed on patients under SCT proposals. The Alliance believes that the Act should specify that conditions which need to be adhered to should be culturally appropriate.

BME groups are concerned that examples of harm to patients caused during detention under the MHA would be more difficult to monitor if compulsion was extended into the community. The Alliance recommends that provisions for monitoring and review of patients detained in the community should be explicit in the Government's proposals.

Do you think this evidence is adequate? If not, what other information do you believe is required/ would you have found useful?

There is very little high quality evidence from the UK and overseas on community treatment orders. In particular there is a lack of research which has focussed specifically on ethnic variations in its use. As a result we do not have adequate indications of who might be subject to SCT provisions in England and Wales.

Are there other people who may be affected by the amendment whose views should be considered?

Practitioners might be affected by the introduction of SCT, as evidence suggests that increased coercion can do damage to the therapeutic relationship, making their jobs harder.

Police should be consulted as they will likely be involved in enforcement procedures (i.e. conveying patients to hospital for treatment if they fail to comply). There are already fragile relationships between BME communities and the police, and any increase in their powers in relation to mental health legislation could cause further damage.

Experience from overseas (Community Treatment Orders: International Comparisons, John Dawson 2005) shows that most people on CSTs are in receipt of depot medication which is all that can be effectively monitored in the community. If it is the case that this remains disproportionately true for BME communities then the use of CST is likely to perpetuate the over use of coercion for this group.

Risk of adverse effects on race equality:

Highly likely to have adverse effect on race equality - High risk

Potential for benefit:

Probably will not promote race equality - Low potential (high risk) Low potential

How big is the risk (in terms of both the number of people who could be affected and the severity of the problem)

Lots of people from many racial groups may be affected to some extent

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

The Government should ensure that SCT is only imposed on a clearly defined and clinically identifiable group of patients – in combination with narrower conditions for compulsion.

The Alliance believes that the condition stating that SCT can only be prescribed where services are available in the community should specify that these services must be culturally appropriate. We support the principle behind the BME Network recommendation to require the detaining authority to consult with such persons, or community organisations that have knowledge of patient's social and cultural background.

The Alliance believes that the Act should specify that conditions which need to be adhered to should be culturally appropriate.

The Alliance recommends that provisions for monitoring and review of patients detained in the community should be explicit in the Government's proposals.

Amendment four: To broaden the group of practitioners who can take on the role of the approved social worker (ASW) and responsible medical officer (RMO) in the Mental Health Act, and replace these roles with the Approved Mental Health Professional and Clinical Supervisor respectively.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

Only if positive steps are taken (a) to promote the training of minority groups among the new professionals and (b) to train all new staff in cultural and racial awareness

Is there public concern/are you or people you know concerned about the possibility that the proposed amendment could cause discrimination and could damage good race relations?

No

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

See above. The key issue here is the need for sensitive and high quality training in cultural and racial awareness.

Where ever the 'Approved Mental Health Professional' (AMHP) (the successor to RMO) is mentioned in the course of amendments to the Act, there should be a clause stating that the person should have 'those skills that are appropriate for working in a multicultural society'.

Amendment five: To strengthen the Mental Health Review Tribunal as a patient safeguard against long term detention without independent review

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

No but we support these proposals

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

The key issue in relation to Tribunals is to widen membership as many BME people are reported to find the Tribunal unhelpful and intimidating because it is staffed by white authority figures. Please see below for more detail.

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

Membership of the Mental Health Review Tribunal does not specifically include people from black and ethnic minority groups 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 all Tribunal members are trained in cultural competency.

An amendment to Schedule 2 of the 1983 Act should ensure that (a) the legal persons appointed by the Lord Chancellor should have knowledge of the race relations law; and (b) the non-legal, non-medical persons appointed by the Lord Chancellor should have training on anti-discriminatory practice.

An amendment to Section 72 (Power of Tribunal) should enable a Tribunal to direct the detaining authority to seek additional information on cultural background of the patient.

Amendment six: To remedy a human rights incompatibility and bring the Act into line with the Civil Partnership Act 2004 in relation to Nearest Relative provisions.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes. The default list of nearest relatives relates more to a nuclear family than to an extended family and would potentially leave out the person with whom the patient might have the closest most nurturing connection. This then places a greater burden on the person to apply for replacement of the nearest relative. However access to the justice system is the most difficult generally for many BME groups and the current mechanism, access to the County Court is woefully unrealistic.

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

No

Is there public concern/are you or people you know concerned about the possibility that the proposed amendment could cause discrimination and could damage good race relations?

Yes

What evidence, if any, have you used to support the conclusions you have reached?

Only anecdotal evidence

Do you think this evidence is adequate? If not, what other information do you believe is required/ would you have found useful?

No. Research into use of nearest relative provisions which identifies race and culture should be undertaken

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

It is essential that all patients be given the opportunity to choose their nearest relative.

Amendment seven: The Bill will also be used as the vehicle for introducing the Bournewood safeguards, through amending the Mental Capacity Act 2005. These safeguards are for people who lack capacity and are deprived of their liberty but do not receive the safeguards of mental health legislation.

Is there potential for or evidence to suggest that the proposed amendment will affect some racial groups differently?

Yes. But lacking the detailed proposals (except in confidence) the Alliance can not comment in detail.

There is potential that the proposals to remedy the 'Bournewood gap' could fail to assist patients from a BME background equally with those from the general population. In answer to the questionnaire therefore we say that the proposals will have a negative impact and will fail to deliver or promote equality.

It must be noted that the group of patients being considered may have little cognitive functioning. They are likely to lack capacity in respect of almost all areas of their life and to require high levels of care and supervision. Clearly adequate measures for their protection should have a central place in mental capacity legislation. With the right processes in place the need to deprive them of their liberty should be the exception where a serious risk of harm to themselves warrants it. Our concerns for patients from an ethnic minority background stem from the particular disadvantages they face because of language, colour, stereotyped attitudes, and social exclusion. Naturally this generalisation has many exceptions in individual cases and applies to differing extents among the different cultural groups There are two groups of particular concern – people with learning difficulties and those with dementia or other age related mental conditions.

Is there potential for or evidence that the proposed amendment will promote equality of opportunity and good race relations?

No

What evidence, if any, have you used to support the conclusions you have reached?

The nature of the proposals is to rely very heavily on the assertiveness of family members to take action for the benefit of the Bournewood patient. There MUST be instead a proper system of advocates to assist the patient and family.

The relatively young age structure of minority ethnic groups means that they are the fastest ageing groups within the population. Just over 7% of the total minority ethnic population is aged 65 and over, but this will increase as a further 12% of those who are presently middle-aged (aged 45 - 64) become pensioners[5]. Older people from minority ethnic communities tend to have been born outside of the UK. Virtually all (97%) people from minority ethnic communities aged 45 and over are born outside of the UK. However, this proportion will change over time because between 1997 and 1999 90% of the total minority ethnic population children aged 0-14 were born in the UK[6]

It is well know that there are differential rates in accessing health services among different ethnic groups. Lack of access arises because of user ignorance, language and literacy

[5] Labour Force Survey: population size, percent distribution by age and median age by ethnic group, 1997 - 1999 GB. ONS

[6] Scott A, Pearce D and Goldblatt P. 'The sizes and characteristics of the minority ethnic populations of Great Britain: latest estimates, Population Trends, 105, Autumn 2001: pages 6-15).

difficulties, cultural differences (relating to religion, gender or work patterns) and location of service delivery. Poor knowledge and experience of services are barriers that obstructed access to services by elderly people[7].

Older people in hospital receive a different level of service dependent on their command of the English language. Food quality and quantity is often inadequate; and there is a need to employ more nurses from minority ethnic groups[8].

Older people from black and minority ethnic communities do not always receive appropriate social care. Reasons for this include: language barriers; insufficient knowledge of availability and rights to social and public services; low expectations of their life in the UK; negative experiences of retirement; poor mental and physical health; racism - both overt and often inadvertent - at individual and institutional levels, including professional assumptions that their family will provide care and a colour-blind approach to service provision and assessment; inadequate support from their family; and lack of consultation with black and minority ethnic communities in service planning and delivery.[9][10]

Lack of access to information and public services can result in older people from black and minority ethnic groups being socially isolated from their peers. Evidence shows the importance that older people from black and minority ethnic groups place on being close to family or other people from the same ethnic background and to local facilities.[11] [12] According to Age Concern research there are currently very significant numbers of South Asian and Chinese/Vietnamese elders who face language barriers in accessing care services. It is unrealistic to imagine that people who have reached a certain level of maturity can learn a new language[13].

In your view, what action (if any) is needed to ensure that the amendment is fairly applied to all racial groups? And, if you think action is needed, who do you believe should be responsible for taking this action?

We believe that this evidence indicates that large numbers of people from ethnic minority groups, particularly those of first generation who are ageing, face significant additional barriers when they lack capacity and are in residential institutions.

We believe that this makes it essential that advocacy services should be required by statute to be made available for them (and funds provided for this to be a reality), irrespective of whether they are 'befriended' and whenever there is a risk that they may lose liberty. This is particularly needed as their carers may also have similar characteristics associated with low socio economic status and social exclusion.

We consider that for this most disadvantaged group the Court of Protection is simply inaccessible. It will be important when any issue arises that the person be present for interview and that this can only occur in any meaningful way in a hospital setting. We recommend the MHRT be appropriate.

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[7] The Centre for Health Studies at Warwick University

[8] Help the Aged and Policy Research Institute on Ageing Ethnicity report on the experiences of black and minority ethnic older people while in hospital ; Help the Aged (2001) Dignity on the Ward. Towards Dignity: Acting on the lessons from hospital experiences of black and minority ethnic older people .

[9] Yu, S.W.K (2000) Chinese Older people: A need for social inclusion in two communities. Bristol/ York: The Policy Press/ Joseph Rowntree Foundation.

[10] National Black Carers Network in association with the Afiya Trust (2002) We care too: A good practice guide for people working with black carers

[11] . Age Concern (2001) When a House is Not a Home: Older people and their housing.

[12] Age Concern: Consultation Events with Black and Minority Ethnic Elders, North London, Yorkshire and North-east England 2000.

[13] Similar points are made in 'Black and Minority Ethnic Elders in the UK Health and Social Care Research Findings' October 2005

We also consider that the likely plight of the most disadvantaged of the Bournewood patients makes it essential that the safeguards proposed are put in place in statute in order to avoid a deprivation of liberty, rather than the present situation in which it appears that a new detention regime is being set up for the benefit of these patients. We consider the current approach most objectionable. Loss of liberty should be the last resort (and is usually an indication of institutional system failure). We have genuine concerns for a group for whom communication difficulties and unintentional racist attitudes are more likely than for other groups, that proposals will lead to the simple option of using deprivation of liberty rather than trying more human rights compliant methods of delivering care. Training will not in our view be able to eradicate these problems – certainly in the absence of legal obligations.

Additional Mental Health Alliance policy

Right to an assessment

It is well documented that people from BME (Black and Minority Ethnic) communities, and African Caribbeans in particular, fare worse under the mental health system. A Sainsbury Centre' report describes "Circles of Fear", through which Black people, over-represented in services and typically having a negative view of the psychiatric profession, are exposed to the rough end of mental health services, yet fail to access the community, primary care and mental health promotion services that might break the cycle.

At first presentation of psychotic symptoms, patients seeking help themselves and accessing services through their GP are also more likely to use services voluntarily[14]. African Caribbean and Black African groups are less likely to seek help themselves[15], and the census showed that Black Caribbean, Black African and Other Black groups were 40-70% less likely than average to be referred to inpatient care via their GP.

According to the census, Black Caribbeans and Black Africans were twice as likely to be referred by the police, and Black Caribbeans were almost twice as likely to be referred via the courts. Where family members seek help on a person's behalf, family members of an African-Caribbean patient are significantly more likely to turn to a police officer for that help than the families of White patients[16]. The 2003 literature review again showed more police involvement in referral for Black groups, more people presenting to services in a crisis from this group and concluded that overall, their pathways to care are more complex than for White people[17].

The Pre-Legislative Scrutiny Committee on the 2004 Draft Bill supported the idea that an individual should be able to request an assessment for services, and that there should be a duty on authorities to give written reasons if they do not agree to do this. The Scottish Mental Health (Care and Treatment) Act 2003 also contains such a provision.

The Alliance believes that giving all people the right to an assessment for mental health needs if they or their family request it would enable BME groups to use mental health services in a more positive way. It would reduce the likelihood of these groups arriving at services at a point of crisis, or being picked up first by the police or courts. Introducing such a right might go some way to breaking "the cycle of negative experiences, coercion, disengagement and relapse that often characterises Black patients' experience of mental health care in the UK".[18]

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[14] Morgan C, Mallett R, Hutchinson G, Bagalkote H, Morgan K, Fearon P, Dazzan P, Boydell J, McKenzie K, Harrison G, Murray R, Jones P, Craig T and Leff J: Pathways to care and ethnicity. I: Sample characteristics and compulsory admission, Report from the AESOP study, British Journal of Psychiatry, 2005, 186, 281-289

[15] Morgan et al, 2005, op. cit.

[16] Morgan et al, 2005, op. cit.

[17] Bhui et al 2003, op. cit.

[18] Morgan et al 2005, op. cit.

Advocacy

The right to advocacy is particularly important in the cases of people from BME communities. Black groups have been shown to be more socially isolated and this isolation affects both their pathway into the compulsory mental health system and health outcomes[19]. Early access to advocacy could provide BME patients with extra support and "facilitate communications, reduce anxiety on both sides and [to] ensure that appropriate solutions are offered"[20]. However, the recourse to advocacy, tribunals and to appropriate care packages has been slow to positively impact these communities.[21] The Alliance is therefore very disappointed that the Government has withdrawn its proposal to introduce advocacy as part of the legislation.

The Alliance believes that there should be a universal right to advocacy from the initial assessment stage, as recommended by the Joint Committee[22]. 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.

Patients should have access to appropriately trained advocates and that training should include training in cultural diversity. In appointing advocates the appropriate authority should be obliged to appoint a sufficient number of people from diverse communities with adequate training. The Government should also make a commitment to appointing a sufficient number of people from diverse communities with adequate training.

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. According to the census, Men from Black Caribbean, Other Black and Black/White groups were more likely to be staying on a medium or high secure ward than the average. Men from Black Caribbean, African and Other groups were significantly more likely to be placed in seclusion than the national average, and Black Caribbean men were 29% more likely than the average to be subject to control and restraint procedures. The potential for harm is greatest when patients are subject to such procedures, as highlighted by the high profile deaths of a number of African Caribbean service users, such as David 'Rocky' Bennett, in mental health care.[23]

Current safeguards around the use of control and restraint are inadequate in terms of their scope and application. Currently NICE's (National Institute for Clinical Excellence) 2004 Clinical Guidance on the short-term management of disturbed/ violent behaviour in psychiatric and inpatient settings stipulates that staff may be expected to engage in prone position restraint with full awareness that this may contravene Article 2 of the European Convention on Human Rights.[24]

Most significantly the Human Rights Committee, in its Third Report on Deaths in Custody (Para 256) states:

"*The possibility that racial stereotyping has been a contributory factor in at least some deaths in custody resulting from restraint should be taken seriously, by both police forces and NHS trusts, as an alert to the risk of a breach of Article 2 ECHR, of Article 14 ECHR read with Articles 2, 3 and 8, and of the obligations of police forces under the Race Relations Acts.* The perception of

[19] 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.
[20] Sainsbury Centre for Mental Health Breaking the Circles of Fear: a review of the relationship between mental health services and African and Caribbean communities. 2002, SCMH
[21] Songhai, written evidence to the Joint Committee, (2004), EV 1060
[22] Joint Committee Recommendation 88
[23] African & Caribbean Mental Health Commission, written evidence to the Joint Scrutiny Committee (2004)
[24] Joint Committee On Human Rights - Third Report: Evidence EV 8 Physical restraint and seclusion

discriminatory use of restraint is supported by what is generally acknowledged to be patchy compliance with ACPO guidelines on restraint, and variation in the training in restraint techniques provided to police officers. *Race equality schemes under the Race Relations (Amendment) Act need to provide for measures to prevent discrimination in the use of restraint. We emphasise the need for training of all staff who may be involved in control and restraint, to include cultural awareness in its use. This obligation arises both under the Human Rights Act and under the positive duty to promote race equality in the Race Relations (Amendment) Act 2000. Such training should be to national standards and delivered by accredited trainers..."*

The Mental Health Alliance is particularly concerned that not addressing this issue may breach the State's most fundamental duty not to deprive the individual of life. We also believe that not doing so might seriously undermine ethnic minorities confidence in the mental health services, contrary the Department Of Health's Delivering Race Equality Action Plan. Regulations on the use of control and restraint should be validated in law to provide a legal basis for accountability and make clear which techniques are appropriate.

The enquiry into the death of David Bennett recommended a maximum three-minute time limit on prone restraint[25]. The Joint 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.[26]

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"

Given the later House of Lords decision in the Munjaz case, there is an even stronger justification for ensuring that regulations on the use of treatment and restraint should appear on the face of the Bill.

Treatment safeguards

It is well documented that African Caribbeans are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage[27]. The Bennett Inquiry found that 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 is concerned by the use of police stations as a 'place of safety'. Mind estimates that, despite the Mental Health Act Code of Practice advising that police cells should not generally be

[25] Independent Inquiry into the Death of David Bennett.
[26] Joint Committee Recommendation 81
[27] Sainsbury Centre for Mental Health Breaking the Circles of Fear: a review of the relationship between mental health services and African and Caribbean communities. 2002, SCMH

used, in practice police cells are used on about 80% of occasions when section 136 powers are evoked.[28]

The Joint Committee on Human Rights stated:

"For as long as police cells continue to be used for these purposes, even in rare cases, the police have obligations under Articles 2, 3, and 8 to protect the safety of people detained in this way by addressing their particular needs. Compliance with Article 2 in the detention of a person known to be seriously mentally ill, and who may be at risk of suicide, requires informed psychiatric assessment and treatment, and expert monitoring. These are standards which it will be extremely difficult for police custody suites, even the best equipped, to meet. *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 ."*

This is of particular concern from a race equality perspective given the evidence that Section 136 is used disproportionately amongst people from BME communities [29]. While the Alliance welcomes additional investment in more appropriate 'places of safety', we believe that the 1983 Act should include a requirement 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, as recommended by the Richardson Committee.

Tribunals

Membership of the Mental Health Review Tribunal does not specifically include people from black and ethnic minority groups 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.

Right to move hospital

[28] Lord Adebowle – Q875 Evidence to the Joint Committee

[29] 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..

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.

Additional Recommendations

The Alliance is also calling for:

A commitment by Government to adjust its amendments in the light of evidence received as part of the REIA consultation
A robust and comprehensive Race Equality Impact Assessment is an extremely important part of the review of legislation and it must be given full consideration. It is necessary to allow those most affected to have an opportunity to contribute fully, and to ensure sufficient time is allocated to the process to give full consideration to all responses received, so that adjustments can be made before a Bill is introduced into Parliament.

A commitment by the Department of Health to ensure that responses to the REIA represent the breadth of public opinion on race equality and amending the Mental Health Act
We have previously raised concerns that the questionnaire used to elicit responses for the REIA consultation is overly complicated and likely to be inaccessible to service users and others who may not be trained in policy work. We are concerned that this may have an impact on the number of responses you receive and how representative the information you gather will be as a result. We would ask that if there are very few responses to the questionnaire, the Department of Health takes further steps to capture the views and recommendations of a wider group of people.

Thorough consultation with Criminal Justice Agencies before the amendments are finalised
There is a cycle of poor relations between BME communities and criminal justice agencies which has a negative impact on these BME patients' experiences and perceptions of care in the mental health system. On the one hand, Black patients are significantly more likely to have had previous contact with forensic mental health services or prison[30], and are more likely to be detained with the involvement of the police or courts according to the 2005 census (see above). On the other, the Stephen Lawrence Inquiry[31] exposed the fact that there is institutional racism within the Metropolitan police service across England and Wales. The report acknowledged that the police, and in particular custody officers, do not have adequate training about mental health issues and are under-prepared to deal with people who may be distressed and demonstrating disturbed behaviour. The Metropolitan Police Force and other criminal justice agencies should be fully consulted during the process of reform and their needs, including adequate training, should be incorporated into implementation planning and guidance.

I hope that this submission is useful in informing your work, to ensure that race equality is a priority in amending the 1983 Mental Health Act.

Yours sincerely,

Paul Farmer
Chair,
Mental health Alliance

[30] 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.
[31] Home Office (1999) The Stephen Lawrence Inquiry, McPherson Report, Home Office.