ISSUES RELATING TO BLACK AND MINORITY ETHIC COMMUNITIES

British society is both multicultural and multiracial, and from this comes the need for mental health legislation that reflects and acknowledges vital issues around 'culture' and 'race', and counteracts institutional racism.[1] The Alliance believes there is a need for an appropriate multi-cultural approach to mental health that aims to provide the creation and delivery of racially and culturally appropriate mental health services.

It is well documented that people from BME communities, and African Caribbean's in particular fare worse under the mental health system. African Caribbean men are five times more likely to be detained on locked wards and are six times more likely to be sectioned under the Mental Health Act 1983 despite having similar rates of mental ill health as other ethnic groups.[2] There is a history of misunderstanding and discrimination when it comes to the use of compulsory powers against African Caribbean's.[3] This 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's are more likely to be misdiagnosed and diagnosed with psychotic conditions and treated using medication, which is often of a higher dosage. Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression. The recourse to advocacy, tribunals and to appropriate care packages has been slow to positively impact this group.[4]

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

"*There is a history of misunderstanding and discrimination, we would say, when it comes to the use of compulsory powers in the mental health system. There are very complicated reasons as to why that has happened. We are more interested in stopping that happening in the future, and we are concerned about the Bill, as currently drawn, not stopping that in the future*."[5]

Principles

The Alliance believes that the principles of equality, non discrimination and respect for diversity should be included in the Bill and should be in the body of the legislation without any method of dis-application. This will remind professionals when taking important decisions under mental health legislation of the need to give respect to the qualities, abilities and diverse backgrounds of individuals and the need to avoid making general assumptions on the basis for example of ethnic cultural and religious stereotypes.

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[1] Home Office (1999) *The Stephen Lawrence Inquiry Report*
[2] Office of the Deputy Prime Minister, (2004) *Mental Health and Social Exclusion Report*
[3] Sainsbury Centre for Mental Health (2002) *Breaking the Circles of Fear,* SCHM
[4] Songhai, written evidence to the Joint Committee, (2004), EV 1060
[5] Chinyere Inyama (mental health lawyer) oral evidence to the Joint Committee Q872

This should be part of a wider Government commitment to joined-up thinking across departments to ensure that the Bill is linked to other Government initiatives and anti discrimination legislation, such as the Race Relations Amendment Act, the Disability Discrimination Act, the Children Act and the Sex Discrimination Act.

Dangerousness

We are concerned at the draft Bill's emphasis on the perceived 'risk to the public' and 'dangerousness', in particular the conditions for compulsion and the determination of what is called 'substantial risk of causing serious harm to other persons', will impact disproportionately on people from BME communities.[6]

Previous inquiries have shown, race is often seen as an index of dangerousness. In 1993 there was a major inquiry into the death of three Black men at Broadmoor Hospital, it highlighted the perception of those delivering health care in the mental health system about race as an index of dangerousness.[7] In 2003, with the death of David Bennett, the inquiry report made similar sentiments; and again in May 2004 with the death in similar circumstances of a young Asian man, Azrar Ayub in Manchester.

The Alliance supports the concerns expressed by the National Black and Minority Ethnic Mental Health Network:

"The Bill's 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." [8]

Advocacy

The right to advocacy is particularly important in the cases of people from BME communities. We consider the right should be for patients to have access to appropriately trained advocates and that training should include training in cultural diversity. Therefore in appointing advocates the appropriate authority should be obliged to appoint a sufficient number of people from diverse communities with adequate training.

Non resident orders (NRO)

We believe non resident orders will disproportionately affect African Caribbean service users and will exacerbate the current over representation of Black people in the mental health system.

The Government's proposals for non resident orders are contrary to the spirit of their attempts to eradicate the ethnic inequalities within the mental health system through strategies such as Delivery Race Equality. The success of such strategies depends on the development of trust and co-operation of African Caribbean communities using and

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[6] Clauses 9 (7) and (8)

[7] HMSO (1993) *Big Black and Dangerous: Report of the Committee of Enquiry into the Death in Broadmoor Hospital of Orville Blackwood*. *Review of the Death of Two other Afro Caribbean Patients*. HMSO.

[8] Written evidence to the Joint Committee DMH 241

working with mental health services, which is likely to be undermined by the introduction of non resident orders as currently set out in the draft Bill.

We sympathise with the views expressed by Dr Kwame McKenzie: "*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*"[9]

However, if the Government does decide to press ahead with the introduction of non resident orders we would like to see safeguards to ensure that people from African Caribbean communities are not disproportionately subject to these provisions on the basis of stereotypical views and institutional racism.

Criminal Justice System

The Alliance is opposed to the new police power to enter premises and forcibly remove a patient from their home without a warrant. We believe it is highly likely that this power will be disproportionately used against African Caribbean communities who are already subject to over policing and further damage the relationship between BME communities and the police.[10] Black people are six times more likely and Asian people almost twice as likely to be stopped and searched by the police as white people.[11] In light of the negative experiences of people from African and Caribbean communities have with the police these additional powers would further disadvantage them.

We are also concerned by the use of police stations as a '*place of safety*'; for example Mind estimates that, despite the Mental Health Act Code of Practice stating that police cells should generally not be used in practice, police cells are used in about 80% of occasions when section 136 powers are evoked.[12] This is particularly concerning given that this will disproportionately people from BME communities.

The Stephen Lawrence Inquiry exposed the institutional racism within the Metropolitan police service across England and Wales, and also acknowledged that the police, particularly custody officers, do not have adequate training, if any, about mental health issues and especially when a person is distressed and causes disturbed behaviour[13].

Tribunals

Membership of the MHT does not specifically include people from black and ethnic minority groups and we believe this is crucial to ensure that the 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

[9] *Joint Committee on the Draft Mental Health Bill: Evidence EV 554*, Supplementary memoranda from the BME Network (DMH 445), *Addendum Three: Diverse Minds.* Contribution by Marcel Vige, Diverse Minds Manager.
[10] The 1990 Trust, (2004) *Stop and Search: A community evaluation of Recommendation 61 in the London Borough of Hackney*. A study conducted for the Metropolitan Police Authority
[11] *Race and the Criminal Justice System: an overview to the complete statistics 2003/2004(*Home Office 2005) (statistics from section 95 of the Criminal Justice Act 1991)
[12] Lord Adebowle – Q875 Evidence to the Joint Committee
[13] Home Office (1999) The Stephen Lawrence Inquiry, *McPherson Report*, Home Office.

- 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. This is especially important considering that under the 1983 Act, African-Caribbean people are more likely to be detained and receive higher doses of medication than the population as a whole. We recognise and welcome that the Expert Panel will include people with experience in ethnic minority issues but there is a danger that such issues will be seen to be of secondary importance or treated in a superficial way unless Tribunals include BME representation.