Editorial

Rachel Perkins and Julie Repper

Compulsion and race: over-representation and time to act decisively

In October 2019, the latest Mental Health Act statistics were published (NHS Digital, 2019). Yet again, they make grim reading.

In 2018–2019 there were 49,988 new detentions under the Mental Health Act 1983 – with 15.5 per cent being detained more than once in the year – and 4,840 Community Treatment Orders issued but "[…] the overall national totals will be higher. Not all providers submitted data, and some completed incomplete data" (NHS digital, 2019, p. 2).

The 2018–2019 rate of Mental Health Act detentions represents a 2 per cent increase over 2017–2018 figures (NHS Digital, 2019). Indeed the figures have risen by at least 2 per cent each year from 2015–2016 (see NHS Digital, 2017, 2018). Direct comparisons of numbers prior to this are not possible because the way in which data are collected has changed, but what is absolutely clear is that the rate of detentions under the Mental Health Act has been rising inexorably:

> Rates of compulsory detentions in psychiatric hospital have more than doubled since 1983, with the steepest rises in the last decade and late 1980s/early '90s. From 2005-06 to 2015-16, the reported number of uses of the Mental Health Act to detain people in hospital increased by 40%. (Independent Review of The Mental Health Act, 2018, p. 49)

These increasing detention rates strongly suggest that there is much work to be done to improve access to, acceptability of, and experience of mental health services for everyone who experiences a mental health crisis. Numerous initiatives have been aimed to extend the range of options available to people in crisis, including sanctuaries, safe havens, crisis houses and crisis cafes: The NHS England (2019) Long Term Plan commits to increasing the availability of such options and ensuring that people can get help when they are in crisis 24h per day. In 2014, the Department of Health set up local Crisis Care Concordats, designed to facilitate access to care before crisis point is reached, improve the quality of crisis care and treatment, and prevent future crisis. Yet despite this, the data tables associated with the NHS Digital (2019)[1] show that the number of uses of Sections 135 and 136 "Place of safety" orders has risen from 15,050 in 2016–2017 to 19,023 in 2018/2019. The situation remains similar to that described by the Care Quality Commission in 2015. They emphasise that, while pockets of good practice exist, the quality of support people receive in crisis depends on where you live and when you seek help:

> […] too many people in this situation are unable to access the help they need, when they need it, and are dissatisfied with the help they have been given. (Care Quality Commission, 2015, p. 2)

> […] our work has also shown that far too many people in crisis have poor experiences due to service responses that fail to meet their needs and lack basic respect, warmth and compassion. This is unsafe, unfair and completely unacceptable. (Care Quality Commission, 2015, p. 4)

Until everyone has somewhere accessible and acceptable to go when they are approaching a crisis – a place where they know they will be treated with understanding, compassion and dignity – it seems unlikely that the rising tide of compulsory detention and treatment can be stemmed.

However, behind these overall rates of detention, gross inequalities can be found.

Known detention rates for men (91.4 per 100,000) are higher than those for women (83.2 per 100,000) and men are more likely to be subject to Community Treatment Orders (11.2 per 100,000 compared to 6.1 per 100,000 for women). Detention rates for younger

people aged 18–34 are about one third higher than those for people aged 50–64 (128.9 per 100,000 compared to 89 per 100,000).

However, inequalities are most stark, and most worrying, in relation to ethnicity (NHS Digital, 2019). In 2018–2019, in relation to "white" people, those from "Black/Black British" communities are:

- over four times more likely to be detained in hospital under the Mental Health (306.8 per 100,000 compared to 72.9 per 100,000);
- more likely to be detained more than once during the year (18.8 per cent compared to 15.5 per cent);
- over eight times more likely to be subject to a Community Treatment Order (53.8 per 100,000 compared to 6.4 per 100,000); and
- twice as likely to be detained under a Section 136 "Place of Safety" order (56.6 per 100,000 compared to 28.4 per 100,000)[2].

Recognition of these differences is not new. Keating *et al.* (2002) described relationships between Black communities and mental health services are driven by a vicious circle of fear:

> We have reached a point in the relationship between the Black communities and mental health services where there are truly Circles of Fear. Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism and not knowing how to respond, and fearful of young Black men. The cycle is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism. (Keating *et al.*, 2002, p. 6)

The prevailing situation in which "[…] Black people are 40% more likely to access treatment through a police or criminal justice route, less likely to receive psychological therapies, more likely to be compulsorily admitted for treatment, more likely to be on a medium or high secure ward and more likely to be subject to seclusion or restraint […]" (Mind, 2019, p. 1) can only further fuel these Circles of Fear.

> There was a perception that MH services replicate experiences of racism and discrimination of black people in wider society, particularly those instances where individuals have experienced the more controlling and restricting aspects of treatment […] the way services respond to them mirrors some of the controlling and oppressive dimensions of other institutions in their lives; for example, exclusion from school, or contact with police and the criminal justice system. (Keating and Robertson, 2004, p. 442)

The research conducted by Keating *et al.* (2002) concluded that:

- the Circles of Fear described above discourage Black people from engaging with services;
- mainstream mental health services are viewed as inhumane, unhelpful and inappropriate by Black service users who feel that they are not treated with respect and that their voices are not heard;
- as a consequence Black communities are reluctant to engage with services and Black people tend to come to services late – when they are already in crisis – thus reinforcing the Circes of Fear;
- there is a lack of community based crisis support and Primary Care involvement and acute mental health care is perceived negatively and not considered to aid recovery;
- there is a divergence of models and descriptions of "mental illness" between Black communities and mental health services, and different philosophies and world views are not recognised or understood;
- there is a lack of service user, family and carer involvement;
- conflict between professionals and service users is not always addressed in helpful or constructive ways;
- while the concept of "culture" has been invoked to address some of these issues, this can detract professionals from looking at individual histories, characteristics, values and wishes;

- Black-led community initiatives are not valued: their funding is often insecure preventing long-term capacity building; and
- stigma and social exclusion are important dimensions in the lives of Black service users.

On the basis of this research, the authors argue that "A wide ranging programme is needed to break the circles of fear addressed both to the statutory sector and to the Black communities" (Keating *et al.*, 2002, p. 10). A number of recommendations for national and local action were made, although it is hard to argue that these were really heeded or fully implemented.

However, in 2005, a major five-year national programme – delivering race equality in mental health – was launched "[…] an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status […]" (Department of Health, 2014, p. 3). This programme was designed to create more appropriate and responsive services, improve community engagement (including the employment of 500 new Community Development Workers) and provide better information (via an annual "Count Me In" census). Among the specific aims of the programme was the ambition that, by 2010 there would be "less fear of mental health services among BME communities and service users" and "a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units" (Department of Health, 2014, p. 4).

The continuing over-representation of Black and Black British people among those compulsorily detained and forcibly treated under the Mental Health Act shows that these aims were not achieved. As the final report of the Independent Review of the Mental Health Act 1983 stated:

> Profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes. We know that people of black African and Caribbean heritage are more likely than white British people to come into contact with mental health services through the criminal justice system, rather than via their GP or referral to talking therapies. Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the Mental Health Act. (Wessely, 2018, p. 163)

This review was specifically charged with addressing these disparities and made a number of recommendations. Like delivering race equality in mental health it emphasised involving service users, carers and communities and made a series of recommendations (see Wessely, 2018, pp. 172/3):

- the implementation of a community-driven "Organisational Competence Framework" and "Patient and Carer (Service User) Experience Tool" across health and social care services building on work conducted by NHS England to develop the Patient and Carer Race Equality Framework;
- the Care Quality Commission and the Equality and Human Rights Commission should use their powers to support improvement in equality of access and outcomes and ensure organisations are complying with their public sector equality duty;
- the provision of culturally appropriate advocacy for people of all backgrounds and communities, especially for people of black African and Caribbean heritage;
- the creation of safeguards to ensure that people are able to continue religious or spiritual practices while they are in hospital;
- greater representation of people of black African and Caribbean heritage in all professions (especially psychology and occupational therapy) and at senior levels (especially psychiatry and psychiatric research, psychiatric nursing and management);
- the piloting and evaluation of behavioural interventions to combat implicit bias in decision making;
- the improvement of data and research on ethnicity and use of the Mental Health Act, with all decisions being recorded and reviewed consistently by organisations involved in the process (especially criminal justice organisations and Tribunals);

- funding should be made available to support research into issues that lead to mental disorder in different communities (especially people of African and Caribbean heritage) and intervention that improve outcomes; and
- research into early interventions for children of African and Caribbean heritage, especially those who are at risk of exclusion from school.

Will these succeed where other initiatives and recommendations have failed? Only time will tell.

There is certainly a case for arguing that some of the money currently being invested in crisis services should be targeted specifically to address reducing the over-representation of Back and Back British people among those detained. There is evidence that peer support workers may reduce readmission to acute care (Johnson *et al.*, 2018): there is a strong case to argue that at least some of these should be people with lived experience of acute crisis and detention from Black and Black British Communities.

However, while changing attitudes, values and behaviours, and extending the range of possibilities available is undoubtedly important, has the time not now come to ensure that good intentions are realised in the form of accountable targets for improvement?

Is it not time to say that compulsory detention represents a failure to offer people help that is accessible, acceptable and effective both at times of crisis and to prevent crises occurring? Recognise that this failure disproportionately disadvantages people from Black communities (and indeed other oppressed groups such as Gypsies and Travellers), and start setting targets to both reduce the use of compulsory detention and reduce the over-representation of Black/Black British people among those forcibly detained and treated under the Mental Health Act.

How about setting all mental health services (working in conjunction with communities, service users and partner agencies) the target of achieving:

1. a year on year reduction in the use of compulsory detention;
2. a year on year decrease in the use of Community Treatment Orders and Section 135/136 "Place of Safety" orders; and
3. a year on year decrease in the over-representation of Black/Black British people among those detained and treated under the Mental Health Act.

Services could then be held accountable for achieving such year on year decreases by inspectorate bodies and "special measures" invoked if they fail to achieve these. Would it not be reasonable to argue that, in terms of their Care Quality Commission rating, no service that fails to achieve such decreases can ever be rated as "good" or "outstanding" – at best they could be considered as "requiring improvement"?

Notes

1. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures
2. https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-IndependenteReviewofthehub/mental-health-act-statistics

References

Care Quality Commission (2015), *Right Here, Right Now. People's Experiences of Help, Care and Support During a Mental Health Crisis*, Care Quality Commission, London.

Department of Health (2014), *Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis*, Department of Health, London.

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., Ambler, G., Milton, A., Davidson, M., Christoforou, M., Sullivan, S., Hunter, R., Hindle, D., Paterson, B., Leverton, J.P., Forsyth, R., Mosse, L., Goater, N., Kelly, K., Lean, M., Pilling, S., Morant, N. and Lloyd-Evans, B. (2018), "Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial", *Lancet*, Vol. 392, 4 August, pp. 409-418.

Keating, F. and Robertson, D. (2004), "Fear, black people and mental illness: a vicious circle?", *Health and Social Care in the Community*, Vol. 12 No. 5, pp. 439-47.

Keating, F., Robertson, D., McCulloch, A. and Francis, E. (2002), *Breaking the Circles of Fear*, Sainsbury Centre for Mental Health, London.

Mind (2019), "Discrimination in Mental Health Services", *Mind Legal Newsletter,* June 2019, available at: www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-june-2019/ (accessed 24 November 2019).

NHS Digital (2017), *Mental Health Act Statistics, Annual Figures 2016-2017*, NHS Digital, London.

NHS Digital (2018), *Mental Health Act Statistics, Annual Figures 2017-2018*, NHS Digital, London.

NHS Digital (2019), *Mental Health Act Statistics, Annual Figures 2018-2019*, NHS Digital, London.

NHS England (2019), *The NHS Long Term Plan*, NHS England, London.

Wessely, S. (Chair) (2018), "Modernising the mental health act. Increasing choice, reducing compulsion final report of the independent review of the mental health act 1983", Department of Health and Social Care, London.