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Mental Health Act Reform - Race and Ethnic Inequalities

The Government plans to bring forward legislation to reform the Mental Health Act 1983. Proposals include approaches to reduce the disproportionate number of individuals from Black, Asian and minority ethnic communities subject to compulsory detention and treatment. This POSTnote outlines research on race and ethnic inequalities in relation to the Act, summarises proposals for reform and stakeholder views.

Overview

- The 2021 Reforming the Mental Health Act White Paper includes measures and legislative changes to tackle inequalities faced by those from minority ethnic groups.
- People from most minority ethnic communities are more likely to be detained under the Mental Health Act 1983 than the majority White population.
- There are inequalities in the experiences and outcomes of detention for patients from minority ethnic communities.
- Many experts agree that tackling inequalities relating to the Mental Health Act requires both legislative change and systemic change to the mental health system.
- Stakeholders have welcomed many of the proposals in the White Paper but emphasise the need for wider commitments to improve access, experiences and outcomes for minorities in mental health care.

Background

The Mental Health Act (MHA) 1983 regulates compulsory detention and treatment of people with a mental health disorder in England and Wales.[1] A person can be detained (sometimes called 'sectioned') if they have a mental disorder and are deemed to be at risk of harm to themselves or others. The Act has a range of powers for admission to hospital and community treatment, including via the criminal justice system. This briefing is focused on adults aged over 18.

Although there is variation across ethnic groups, most ethnic minorities in the UK are more likely to be detained under the MHA than their White counterparts.[2–6] Some minorities are also more likely to spend longer in detention, experience multiple detentions and be detained through contact with emergency departments or the criminal justice system.[7–9] The use of the MHA is especially high amongst the Black Caribbean, Black African and Black British population.[2,8,10] The reasons for disparities are complex and are driven by wider inequalities both within and beyond the mental health system (see Box 1).

Recent trends in the use of the Act

Rates of detention in psychiatric hospitals doubled in England between 1988 and 2016.[11] This was largely due to rises in section 2 detentions which permit detention for up to 28 days.. Section 3 detentions of up to six-months or a year were more stable.[11,12] One study that monitored detentions from 1999 to 2016 found that rises in detentions were associated with "the economic recession, legislative changes and the impact of austerity measures on health and social care".[13]

Since 2016/17 NHS Digital has produced statistics on the MHA based on the Mental Health Services Data Set, which has some limitations regarding completeness and accuracy.[14] There were 53,239 MHA detentions in the year 2020/21, a 4.5% increase from 2019/20.[8] This figure is likely to have been impacted by the pandemic when compared with annual increases of between 0.8-2.4% since 2016/17.[15–18] Detentions were highest amongst those aged 18-34 years and are strongly correlated with socio-economic deprivation. Men were 8% more likely to be detained than women.

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Box 1: Wider inequalities in mental health

A recent Commission for Equality in Mental Health notes that high rates of detention amongst minority ethnic groups reflects poorer mental health outcomes and is an indicator that "non-coercive approaches have either been unsuccessful or untried."[19] People from minority ethnic backgrounds are at comparatively high risk of mental ill health, including for diagnoses of severe mental illness such as schizophrenia or mood disorder.[20–22] These groups may be more likely to experience structural inequalities associated with increased risk for mental health disorder, including socioeconomic deprivation, poor and insecure housing, migrant stresses, childhood trauma and substance abuse as well as the lived experiences and consequences of racism.[23–30]

They also experience a range of inequalities within the healthcare system.[3,20,23,31,32] A Race Equality Foundation report found that people from minority ethnic groups were less likely to access mental health services through primary care, more likely to end up in crisis care and 40% more likely to access mental health care via the criminal justice system.[20] Black and minority ethnic people also experience variation and inequality during assessment, are less likely to be offered psychological therapies and more likely to receive drug treatments.[20,33] They are also more likely to report adverse, harsh or distressing experiences and poorer outcomes.[19,34,35] Alternative service models may be provided by the voluntary and community sector, but the range of provision and interaction with statutory services is not well understood.[20,36,37] A recent rapid review for the NHS Race and Health Observatory notes that long term awareness of mental health inequalities has not led to significant improvements in access, experience and outcomes.[35]

Ethnicity and detention

NHS data show that people from minority ethnic groups are more likely to experience compulsory detention than their White counterparts. In 2020/21, rates of detention by ethnicity were:[8]

- **Black or Black British:** 309.4 per 100,000 people.
- **Mixed Ethnicity**: 143.9 per 100,000 people.
- **Other ethnic groups**: 197.4 per 100,000 people.
- **Asian or Asian British**: 96.2 per 100,000 people.
- **White**: 76.2 per 100,000 people.

More detailed ethnicity data show other trends. The highest rates of detention were amongst the category defined as Any Other Black Background (764.4 detentions per 100,000). This group forms part of the broader Black or Black British group which also includes African and Caribbean groups.[8] A review of international data found detention rates of Black people in the UK to be significantly higher than in other high-income, White-majority populations.[2] Amongst Asian subgroups, Pakistani, Bangladeshi and Any Other Asian Background experienced significantly higher rates of detention compared to Indian people.[8,38] The lowest rates of detention were in the Chinese group, which was the only minority sub-category less likely to be detained than the White majority population.[8]

NHS data is based on self-reported ethnicity according to broad categories. Although it illustrates longstanding inequalities, many experts agree that more detailed monitoring and granular data is required to inform research and interventions into race and ethnic disparities. Experts suggest this research should avoid amalgamation of minorities and focus on geographically and culturally distinct groups. Experts also suggest it should compare other factors, such as age, gender, sexuality, education, language and cultural background.[2,20,29,39]

Inequalities in experience and outcomes

Black or Black British people are more likely to be detained for longer and to experience repeated admission, and are more likely to be subject to special MHA detention powers that can be used by the police.[7,8,40,41] Black and mixed ethnicity people also experience higher levels of restraint compared to White people.[42,43] A recent review found a lack of research on the experiences of detention for minority ethnic groups.[44] However, engagement work by the charity Mind reported that many experienced detention, not as "a therapeutic intervention, but as… chemical and physical containment."[45]

Reasons for disparities in MHA detentions

The reasons behind ethnic disparities in the use of the MHA are complex and disputed. A recent systematic review found that most common explanations were unevidenced, and included "increased prevalence of psychosis, increased perceived risk of violence, increased police contact, absence of or mistrust of general practitioners, and ethnic disadvantages".[2] Cultural barriers, such as mental health stigma and distrust of services is another explanation given as to why some people from minority backgrounds may not engage with services or engage later.[35,46,47] However, critics argue that an emphasis on cultural differences may distract from ways that the health system is itself discriminatory.[23,48] Debate on whether mental health services are discriminatory and institutionally racist is longstanding.[23,35,48–53] In 2021, members of the Mental Health Alliance published an open letter to the Government, voicing concern about the lack of recognition of racism in the consultation on reforming the Act and in the White Paper.[54]

Discrimination and MHA assessments

MHA assessments are used to decide whether to detain someone and are usually carried out by an Approved Mental Health Professional (AMHP) and two doctors, one with expertise in MHA legislature.[55] These assessments may be vulnerable to bias and discrimination because of the level of subjective discretion involved.[39,56–58] However, the extent to which disparities in MHA statistics may be impacted by bias and discrimination at the point of assessment is not clear.[20,39,59] Two studies that looked at detention assessments at selected NHS Trusts did not find ethnicity to be an independent predictor of detention. They concluded that some variation in detentions could be explained by location and service provision,[4] or by higher rates of mental illness, greater risk and poorer levels of social support.[60] These studies have been criticised for adjusting for factors that cannot be considered independent of ethnicity and many experts agree that bias and discrimination cannot be ruled out without direct research.[20,39] Focus on bias and discrimination at the point of assessment may be misleading as it does not take into account systemic factors impacting adverse pathways through care.[48]

Criminal justice system detentions

Part III of the MHA has provisions that allow people in the criminal justice system to be admitted to a psychiatric hospital for compulsory treatment, and accounts for around 30% of

detained hospital patients at any time.[8,15] Though accurate data is unavailable, prison populations are understood to have high rates of mental illness, which may be caused or exacerbated by prison conditions and poor access to mental health services.[61–65] Black and minority ethnic people are overrepresented in UK prisons, accounting for roughly 27% of the prison population. NHS digital does not provide annual data on Part III detentions and ethnicity, however, a study from 2000 found Black men were 5.6 times more likely to be admitted to secure psychiatric services than White men.[9]

Background to legislative reform

Since the MHA was last updated in 2007, there have been longstanding calls for reform - including by parliamentary committees - amidst criticism of increasing detentions and Community Treatment Orders (CTOs) and ethnic disparities.[66] The Care Quality Commission (CQC), responsible for monitoring the use of the Act, has raised repeated concerns over annual rises in detentions and ethnic inequalities.[7,67] Addressing inequalities in mental health services is identified as a priority in the NHS Long Term Plan and set out in the Advancing Mental Health Equalities Strategy.[68,69] In 2017 the Government commissioned an independent review to examine issues related to the Act and recommend changes in law and practice (Box 2).

Box 2: The Independent Review of the Act (2018)

The Independent Review consulted extensively with experts and organisations, including patients and carers with direct experience of MHA detention. Expert panels and topic groups reviewed evidence from over 50 focus groups and 1,500 survey responses. It also looked at existing research as well as findings from ten independent studies commissioned by the NIHR Mental Health Policy Research Unit.[70] The review's work on addressing racial and ethnic inequalities was supported by the Mental Health Act Review African and Caribbean Advisory (MHARAC) group. This group carried out consultation, patient surveys and focus group research. It offered recommendations they felt would "support system change, be embedded into the fabric of mental healthcare delivery and sustained over the long-term."[39] The report, Modernising the Mental Health Act, was published in 2018.[58]

The White Paper - major proposed changes

The Independent Review made over 150 recommendations, most of which the Government accepted and incorporated into the 2021 Reforming the Mental Health Act White Paper.[47] The main reforms are outlined in a House of Commons Library briefing.[71] Reforms shift the emphasis of the MHA away from what is seen by some as overly cautious, risk-management legislation to a more patient-centred framework with a focus on human rights. The aim of these changes is to tighten detention criteria and give patients more choice and autonomy (Box 3). Reforms were guided by four principles, which will be embedded in the Act:[58]

- **Choice and autonomy** – ensuring patients' views and choices are respected.
- **Least restriction** – ensuring the Act's powers are used in the least restrictive way.
- **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the Act.
- **The person as an individual** – ensuring patients are viewed and treated as individuals.

The Independent Review noted that the final principle should embed equality into the legislation such that care and treatment provision respects individual diversity, including any protected characteristics under the Equality Act 2010.[58] Although these principles have been in the MHA's Code of Practice since 2007, the CQC found that the code was applied inconsistently.[72] It is hoped that embedding the guiding principles within the Act itself will promote better understanding and awareness.[47]

In contrast to the last reforms in 2007, stakeholders have broadly welcomed the proposals set out in the White Paper. However, most agree that addressing disparities in MHA detention requires wider reforms to mental healthcare and community alternatives to detention, supported by reforms to education, employment and justice.[73–84] The Royal College of Psychiatrists raises a number of practical issues and unintended consequences involved in applying new measures.[85] Many measures are subject to budgetary approval and professional bodies have expressed concern that reforms will not be successful without investment in workforce and services.[84,86,87] Despite the costs involved,[88] some experts argue there is an overall economic case for tackling MHA inequalities.[23,89]

Box 3: Proposals to strengthen patient-centred care

Detention criteria
Current criteria that permit detention in order to protect the health or safety of the patient or others will be replaced with a requirement for "substantial likelihood of significant harm" to the patient's health, safety or welfare or the safety of others. Section 3 detentions and CTOs will also require detention "to bring about a therapeutic benefit".

Autonomy over treatment and care
All detained patients must have a statutory care and treatment plan and patients will be given greater powers to refuse certain treatments. Previously detained patients can state preferences for future treatment in an Advance Choice Document that clinicians will be required to consider.

Independent Mental Health Advocacy
The role of Independent Mental Health Advocates will be expanded to offer more support and representation for detained patients, "subject to funding".

Tribunal review
Patients will have more opportunity and access to MHA tribunals to review their detention.

Criminal justice system patients

The Government states that it will "ensure the benefits of reform" extend to people in the criminal justice system.[47] The White Paper sets out plans to simplify and speed up the process of transfer from prison to hospital and to create a new role to provide better support to patients. Some reforms will not apply to criminal justice system patients, including the requirement that detention provides therapeutic benefit. The White Paper states that patients in the criminal justice system have a "unique risk profile", therefore changing criteria may compromise the ability to adequately protect the public from harm. Stakeholders have raised several concerns about this discrepancy.[90] The CQC points out that some people might only be eligible for treatment via the criminal justice system and that minority ethnic people who are overrepresented in the criminal justice system may be impacted more by this inequity.[78]

Community Treatment Orders

CTOs allow clinicians to order discharged patients to continue supervised treatment in the community and recall patients to hospital if needed. Since their introduction in 2007, CTOs have been controversial. Around 5,000 are issued annually, far more than originally anticipated, and Black people are up to 10 times more likely to receive a CTO than White people.[8,58] A recent systematic review of international data[91] and one randomised control trial in the UK found no evidence that CTOs reduce readmission to hospital.[92] However, the latter study's methodology has been criticised and some experts suggest more research is required to understand how CTOs may be used effectively and who might benefit.[58,93,94] This report found no peer-reviewed research investigating use of CTOs amongst minority ethnic groups, although Mind's engagement work described "a strong sense that CTOs are discriminatory, and some people characterised the powers as 'race surveillance'."[73]

The White Paper proposes strengthening CTO criteria to require substantial likelihood of harm (if not used), and therapeutic benefit, limiting length to a maximum of two years (which can be renewed) and giving more oversight. It is hoped that these changes will reduce overall numbers and give greater scrutiny over subjective decision making and unconscious bias.[39] Many charities view CTO use as evidence of discrimination and bias towards Black patients and continue to campaign for their abolition.[73,80,95] Some experts are concerned that reducing CTOs could lead to detention rises without alternative care.[87]

Wider proposals to address inequalities

The White Paper states that many of the legislative measures outlined above "will begin to address the disparity in outcomes, and in turn detentions".' It also recognises the need for a "multi-pronged" approach and proposes a range of practical measures to address inequalities across the health system, discussed in the following sections.

A Patient and Carer Race Equality Framework (PCREF)[69] was recommended by the Independent Review to drive systemic change and increase accountability for NHS Trusts (Box 4). This is intended to support NHS providers in England to engage with communities, patients and carers and improve access, experience and outcomes for minority ethnic patients. Four pilots are underway,[96–98] and further roll-out is planned subject to an evaluation of the impact of the PCREF.

Culturally appropriate advocacy

Independent Mental Health Advocates support patients to understand and exercise their rights when detained under the Act. The White Paper proposes to expand the role of advocates to offer greater support and improve access to services. Despite recognition of the critical role advocates play, research shows that advocacy is often poorly suited to people from minority backgrounds, although alternative services may be provided by the community sector.[50,58,99–101] The Government is funding pilot studies into culturally appropriate advocacy[102] and aims to bring future legislation to make this provision available to all detained patients, "subject to funding". Though stakeholders support these aims, many have raised concern over the long-term funding of culturally appropriate advocacy and make recommendations where provision could go further.[75,81,84,103,104]

Box 4: Patient and Carer Race Equality Framework

The PCREF was one of the main recommendations of the Independent Review. It will consist of three components:

- National expectations for Mental Health Trusts to fulfil statutory duties under legislation such as the Health and Social Care Act 2012, and the Equality Act 2010.
- Developing a competency framework, focused on areas such as awareness, staff capability, behavioural change, data and monitoring, and service development.
- To embed patient and carer voices at the heart of service improvement, through feedback and consultation.

The PCREF is widely supported by stakeholders as a tool to make service providers accountable to issues of racism and discrimination and to improve racialised patient experiences. The Centre for Mental Health states that unlike previous strategies, the PCREF has equality as its main purpose, clear leadership and the support of national executive agencies, but stresses the need for sustained commitment from government and healthcare providers.[19,105] Data from pilots will be essential for understanding the PCREF's effectiveness.

Role of the police

Police have special powers under sections 135 and 136 of the Act to remove someone from either a private or public space and detain them in a place of safety to await a mental health assessment. They are also routinely present at assessments and police vehicles may be used to transport detained patients to hospital, despite guidance that ambulances are preferred. In 2021 Black people were twice as likely to receive a section 136 as their White counterparts.[8] Police presence can be particularly distressing for Black and minority people who may have poor experiences and distrust in the police, compounded by several high-profile cases of Black people who have died in police custody whilst experiencing mental distress.[50,58,106,107] The White Paper makes a number of proposals aimed at reducing police contact and use of police custody as a place of safety.

NHS workforce diversity

The NHS is the UK's largest employer of minority ethnic people; 21% of staff are from Black and minority ethnic backgrounds.[108] However, underrepresentation of some minorities persists, particularly in senior leadership and certain disciplines.[108,109] The MHARAC group raised concerns about underrepresentation of Black African and Caribbean staff working in psychology and occupational therapy, noting that these services are responsible for delivering non-pharmacological interventions, which are less accessible to Black people.[39,58] The White Paper acknowledges the importance of minority representation across the workforce, mentioning several initiatives such as the NHS Workforce Race Equality Standard. Some studies show that improving diversity and inclusion in healthcare can improve patient outcomes and experiences.[110,111] However, academic stakeholders suggest more research is required to understand this relationship and its impact on mental health pathways for minority ethnic patients.

Future research

The Independent Review also recommended that better data and research could help improve experiences of detention and inform interventions to reduce MHA use for minority ethnic groups. As set out in the White Paper the Government has committed £4m in funding to research, of which £3m has been allocated through the National Institute of Health Research.[112]

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