

## **Race on the Agenda (ROTA) and Race Equality Foundation (REF) submission to the Mental Health Act Review 2018**

### **Summary**

Race on the Agenda (ROTA) and the Race Equality Foundation (REF) are independent Race Equality organisations with health as a specialist area, including mental health service provision. After a wide consultation including a well attended conference we would like to make a number of recommendations to the Review:

1. The Mental Health Act (the Act) should set out principles that define human rights, anti-discriminatory practice and a commitment to combat institutional racism.
2. The Act should be amended to include a clause that states explicitly that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background. And the Act should allow for appeals against diagnoses via a Tribunal, with a panel that includes experts from BAME backgrounds.
3. Patients detained under the Act should be empowered to choose which carers or family members have a say in their care and can support them during an appeals process.
4. A new system of appeal whenever a new diagnosis is applied and/or continued, to a tribunal-like body, with the right of the patient concerned to have legal representation at the hearing.
5. All mental health service providers should be set targets to reduce the use of CTOs and minimize racial inequalities in their use. This should be monitored by the CQC during inspections. Specific amendments in relation to supervised treatment in the community should be made to ensure this is statutory.
6. Statutory bodies should be regularly inspected by the CQC or other appropriate body to ensure that training of professionals working in mental health services addresses issues of racial bias and cultural competence.

### **Introduction**

Race on the Agenda and the Race Equality Foundation welcome the Interim Report issued by the Review as a starting point to build a further evidence base and put forward recommendations. We were glad to see an emphasis on the urgent need to address the disproportionate number of people from black African and Caribbean backgrounds being detained under the Mental Health Act (MHA). Equally, we were unsurprised that Black, Asian and Minority Ethnic (BAME) focus group participants highlighted a **lack of cultural awareness** in staff and a need for culturally appropriate care as paramount. We would express concerns about **racism, stigma, stereotyping and overmedication**. We hope that these findings will guide and underpin the recommendations made in the final report (DOH & SC, 2018).

Black patients are nearly three times more likely to be detained under the Act.

The proportion of **BAME deaths in custody where mental health-related** issues are a feature is **nearly two times greater** than it is in other deaths in custody (INQUEST, 2018). We welcome that the Terms of Reference (ToRs) makes clear that addressing the disproportionate detention of BAME people is a stated aim of the Review.

### **The Mental Health Act**

Mental Health legislation provides a framework for the delivery of mental health services. We are pleased that the Review is willing to focus on solutions beyond legislation – including practice-based solutions. We recognise that legislation alone cannot change attitudes and practices. That said, legislation can influence both practice and attitudes by setting standards and shifting the state-sponsored terms of acceptability. Race Relations legislation, introduced in the 1970s altered employment practices by changing the law, the attitudes of society at large following it.

#### 1. Anti-discriminatory principles and commitment to combating institutional racism

We urge the government to make anti-discriminatory principles an explicit part of the Mental Health Act (the Act). The principles should be modelled on those within the Scottish Mental Health Act 2003, but also include references to race equality and non-discrimination. Race Equality and BAME mental health organisations should co-create the principles with government.

Equally, it is clear that institutional racism is deeply embedded in psychiatry, in both diagnosis and treatment options (Fernando, 2017). As previously discussed, Black Caribbean people are detained more than any other ethnic group under the Act. We are pleased to see that tackling this is a top priority for the Review, featuring in the terms of reference (ToRs). We also welcome that a specific Mental Health Act Review: African and Caribbean Working Group has been established to support the Review going forward.

ROTA recently held a joint conference with the University of East London on the Mental Health Act Review and Institutional Racism, to gather recommendations from academics, practitioners and service users. The need to understand and recognise institutional racism within mental health so we can work to decouple them was raised throughout the sessions. Consequently, we recommend that an explicit acknowledgement of institutional racism as built into mental health services and a duty to reduce it should feature in any new Mental Health Act. Alternatively, an amendment could be made to the current legislation.

## 2. Definition of mental disorder and longevity of diagnosis

Amendments to the Mental Health Act in 2007 removed the distinction between different mental disorders. Although personality disorders now came under this umbrella, none of the diagnostic categories have objective criteria to estimate or measure their seriousness. As a result, there is much discretion left in the hands of practitioners to diagnose patients. An unintended consequence of this space for decision-making is that cultural misunderstandings and any racial bias that practitioners may hold have no checks or balances. To avoid unfair outcomes and discriminatory practice, more stringent measures are needed. Even definitions of 'mind' and 'mental disorder' may have cultural connotations.

The Mental Health Act should be amended to include a clause that makes it explicit that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background. The person making the diagnosis should be aware of the influence of stereotypes and other anomalies that influence judgements made by professionals and others. Additionally, we urge an amendment to the Mental Health Act that allows for appeals (by the alleged patient) against diagnoses via Tribunal, with a panel that includes experts from BAME backgrounds and a supporting family member.

## 3. Duration of diagnosis

There is much concern among many service users, especially BAME people, who often feel that their psychological states have been misunderstood and/or interpreted in a context of institutional racism. Once a diagnosis is given, it often follows them for the rest of their lives. And, since many diagnoses carry a stigma — especially the diagnosis of psychosis or schizophrenia that are given disproportionately to black people — a diagnosis may have widespread disadvantages for the rest of their lives.

To minimize the risk of injustice arising from cultural misunderstandings and institutional racism, we recommend:

- (a) that rigorous standards are drawn up in consultation with appropriate people from BAME community organisations on the process of giving diagnoses; and
- (b) the introduction of a system of appeal (by the patient concerned or their advocate) whenever a new diagnosis is applied and/or continued, to a tribunal-like body that has the ability to call evidence from

outside sources in hearing an appeal, together with the right of the patient concerned to have legal representation at the hearing.

#### 4. Skill base of professionals

In order to work effectively and humanely in a multicultural society where institutional racism is endemic, mental health professionals should have the skill to appreciate:

- (a) cultural diversity in the meaning of ‘mind’ and ‘mental disorder’;
- (b) diversity of interventions and therapies appropriate for patients of various backgrounds; and (c) the pervasive influence of stereotyping arising from sexist and racist perceptions of people that are widely held.

We suggest that legislation is necessary to ensure professionals working in mental health services have the skills necessary to carry out their obligations fairly and without bias. An amendment to the Act with an explicit definition of how this is to be implemented (e.g. through training or supervision of junior staff). Wherever the ‘Approved Mental Health Professional’ (AMHP) or Responsible Clinician (RC) is mentioned in the Act, there should be a clause stating that the person should have ‘those skills that are appropriate for working with patients with protected characteristics’.

#### 5. Training of professionals

The training available for professionals does not sufficiently address the needs of BAME patients. Whilst stereotypes synonymous with institutional racism, such as ‘big black and dangerous’ (SHSA, 1993) and unconscious biases are well documented, many professional bodies that are supposed to supervise and regulate training standards do not pay adequate attention to its pervasiveness.

We believe the Mental Health Act should have provision for the regulation of training instituted by professional bodies concerned with mental health services. Statutory bodies with legally enforceable obligations should be formed and a full annual review of their training procedures carried out.

They should:

- (a) promote better knowledge of the culturally diverse ways in which ‘mind’ and mental health issues are understood in different cultural traditions; and
- (b) ensure that training deals with issues of racial bias and cultural competence.

Alternatively such statutory bodies may be regularly inspected by bodies carrying out the responsibilities of the Mental Health Act Commission (at present the CQC).

#### 6. Community Treatment Orders & community-based supervised treatment

Compulsory admission rates are almost three times higher for black patients than white patients. Community organisations noted their apprehension about CTOs and their potential disproportionate use in 2007 but their warnings have not been heeded (CQC, 2015).

In July 2014, commissioners of mental health services were provided with practical guidance to ensure that inequalities were monitored and addressed. The guidance promotes co-production with patients and carers to achieve a values-based model for commissioning, procuring, and delivering services. Providers should work with local commissioners to consider how they can apply these suggestions in their local area (MHA Code of Practice, 2015; CQC, 2015).

However, this has not brought about change in detention outcomes for black patients. Black patients are nine times more likely to be given a CTO than a White patient (NHS Digital, 2017). The National Survivor User Network (NSUN) highlights the lived experience of CTOs on black people. They felt stereotyped as criminals and this hindered their recovery (NSUN, 2014). The amendments referred to in earlier sections may alleviate this problem to some extent.

An urgent review of Community Treatment Orders is vital. Randomised controlled trials have demonstrated that, despite substantial curtailment of individual freedoms, they confer no benefits to those affected, even after a long term (4 year) follow-up. All mental health service providers should be set targets to reduce the use of CTOs, monitored by the CQC in inspections. Specific amendments in relation to supervised treatment in the community should be made to ensure this is statutory.

#### 7. Mental Health Review Tribunals

Tribunals are perceived by many service users as failing to protect BAME people from unjust sectioning and prolonged detention. The amended Act should make it obligatory for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.

An amendment to Schedule 2 of the 1983 Act should ensure that:

(a) the legal persons appointed by the Lord Chancellor should have experience in the race relations field; and

(b) the non-legal, non-medical persons appointed by the Lord Chancellor should have experience in 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.

An amendment to Section 78 (Procedure of Tribunals) should state that the Tribunal, in arriving at their decision, takes account of cultural diversity and institutional racism.

#### 8. Advocacy

The Mental Health Act allows for patients to have access to independent mental health advocates. Currently, people detained compulsorily can only access this after sectioning. Further, the advocates available sometimes do not have the cultural understanding necessary for BAME patients.

We recommend that access to advocates should precede sectioning, that advocacy should be a right embodied in law, and advocates must be appropriately trained for working in culturally diverse settings.

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