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Psychological Medicine, 44 (2014).

doi:10.1017/S003329171300305X

First published online 13 December 2013

Letter to the Editor

'Ethnicity as a predictor of detention under the Mental Health Act': a response to Singh *et al.*

Ethnic inequalities in detention rates under the Mental Health Act (MHA) have been a consistent and enduring feature of mental health service use in the UK. Any attempt to understand the underlying reasons for this discrepant pattern of service use is welcome.

The authors (Singh *et al.* 2013) claim that ethnicity *per se* does not have an effect on detentions. Based on their data, however, such a conclusion appears to be premature and unjustified. Furthermore, the suggestion that focusing on a single point in the pathway to care [assessment by approved mental health professionals (AMHPs) for detentions under the MHA] can inform the wider debate about structural or systemic inequalities, also called institutional racism, by far exceeds the reach of the study design.

The authors suggest that the appropriate denominator (sampling frame) to determine predictors of detention is those assessed under the MHA rather than the population in contact with services. However, the denominator that they have used is neither the population that is in contact with services *at risk of detention*, nor the total population in whom assessments are triggered.

The sampling frame or denominator in the study is confined to those seen by an approved social worker (ASW) or AMHP in the course of a clinical process eventually resulting in the decision to detain/not detain under the MHA. The decision to detain someone under the MHA is a complex process; patients are identified as requiring compulsory hospital admission usually by their clinical team after testing alternatives, and then referred to an ASW/AMHP on the basis of medical recommendations for admission. ASWs/AMHPs then decide if admission is appropriate. The AMHP's (previously the ASW's) duty, when two medical recommendations have been made, is to decide whether or not to make an application to a named hospital for the detention of the person who has been assessed. The relevance of this for Singh *et al.*'s study is that the decision to detain under the Act or not to proceed with detention (the variation that is sought in the study) would have been made prior to the involvement of the AMHP. Of course, the AMHP assessment could result in the patient not

being admitted (33.8% in the study) but, by and large, referrals to AMHPs result in detention. By that stage, there is sufficient concern by clinical teams in specialist services to conclude that alternatives have been exhausted and the risks warrant detention. This means that the appropriate sampling frame to test the hypothesis, that there is no ethnic bias in detention in hospital, is not those referred to AMHPs but those considered *at risk of detention* earlier in the care pathway because the decision to detain is usually reached before the involvement of the AMHP in this process. If there is likely to be an ethnic bias in the threshold for detention it is more likely to be operating at a stage prior to referrals to AMHPs.

Biases in professional practice, such as ethnic variability in clinical and risk thresholds, are complex and likely to influence decision making across the board (along the care pathway) rather than simply at the point of formal MHA assessment. The authors appear to acknowledge this. They accept that the study 'only shows a snapshot of the complex pathway through services' and 'cannot exclude any ethnic bias that may be operating in who is assessed under the MHA'. Given this important caveat (and the sampling bias in this study), it is misleading to dismiss any ethnic bias in detention under the MHA. It is also an overstatement to suggest that institutional racism does not exist or that confidence in services can be restored. It is precisely this sort of false reassurance, removed from the daily experiences of service users, that leads to less reflective and compassionate care. Professionals need not be paralysed by concerns about ethnic variation, but must grapple with them, as they do with other aspects of their practice, understand such differences and remedy them if inappropriate, or justify it if appropriate.

The study was not blind and the practitioners whose decisions were being scrutinized were aware of the purpose of the study. It is unsurprising that presence of mental disorder (diagnosis) and risk were found to be strong predictors of detention. This is because detention is premised on having a disorder and presence of risk. Without a mental disorder and in the absence of risks, detention would be unlawful. In that sense, it is doubtful whether the presence of mental disorder and risk (which are likely to be linked) can be considered as independent variables. One could argue that judgements concerning risk mediate ethnic differences and should not be included in modelling, as this would conceal true differences.

The study, unfortunately, is not able to address a related factor that may explain ethnic disparities in

detention; that is, the likelihood of ethnic bias in clinical assessment (severity of condition or establishing *nature* and *degree*) and attribution of risk, a process that is less than perfect in the ordinary clinical settings, and especially so during crisis assessments.

Simply examining the outcomes of assessments by AMHPs or medical practitioners, responsible for detention under the Act, is no more likely to reveal such subtle variations in clinical decision-making than studying cohorts of detained patients. This perhaps explains why two previous meta-analyses, one by Singh and funded by the Department of Health, also confirmed ethnic variations in detentions. The findings of the current study by Singh *et al.* are also inconsistent with annual reports from the Care Quality Commission (and its predecessor organizations) on admissions and detentions in hospital.

It would be helpful if future studies like this are able to focus on particular ethnic groups who are most at risk of detention under the MHA. In this study, for example, the ethnic groups who are most likely to be detained are Black and 'Other' ethnic groups, the latter including people of mixed race. Asians have the lowest risk of detention following AMHP assessment. What is required is analysis of data by specific ethnic groups (compared to white groups) to establish how the MHA operates in relation to those ethnic groups who are at highest risk of detention. It is also imperative to include 'upstream' processes' if explanations for variations in clinical decision making are sought.

The data in Table 4 in the paper raise the possibility of a site \times ethnicity interaction, i.e. the relationship between detention and ethnicity is different in different sites. This is a major weakness of the study. AMHPs (ASWs) in London appear to have a much lower threshold for detentions (for all ethnic groups) compared to Oxford and Birmingham. This might be explained by poorer access to alternatives or more co-morbid conditions and other risk factors, such as substance misuse, homelessness, higher population density and higher rates of schizophrenia in London. This site \times ethnicity interaction – reflecting considerable heterogeneity – in this study makes any generalization about sites or ethnicity highly problematical. Interaction between site and ethnicity means that the relationships with ethnicity are different for different sites. The authors attribute the significant regional variation in detention to differences in service provision between London and the other two sites. However, there is insufficient evidence to support such an assertion; differences in clinical practice might equally account for such regional variation. Ethnic differences in detention rates are likely to be susceptible to variations in clinical thresholds.

Finally, any invocation to 'move on from considering racism' in our public institutions must be treated with

extreme scepticism. Such a suggestion is particularly alarming when psychiatrists try to rehabilitate their practice and justify the procedures and processes of mental health care in the face of significant evidence of enduring ethnic inequalities in service experience and outcome. The culture of care within the health service is being closely scrutinized as a cause for concern, so bland reassurances about systems of care, which are not based on hard evidence, are likely to be interpreted as further signs of professional complacency and lack of political will.

What we need is a clear commitment and investment (including research) to understand why people from black and minority ethnic groups continue to be disadvantaged in most aspects of psychiatric care in the UK so that we can seek appropriate and effective solutions to these problems. These concerns are shared by many other patient and public bodies. What is required is a proper scrutiny of such concerns along with comparative analysis of upstream factors.

Declaration of Interest

None.

Reference

Singh SP, Burns T, Tyrer P, Islam Z, Parsons H, Crawford MJ (2013). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*. Published online: 24 June 2013. doi:10.1017/S003329171300086X.

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Psychological Medicine, 44 (2014).

doi:10.1017/S0033291713003061

First published online 13 December 2013

Letter to the Editor

'Ethnicity as a predictor of detention under the Mental Health Act': a response to Singh *et al.* – a reply

We thank Dr Sashidharan and colleagues (Sashidharan *et al.* 2013) for their interest in our paper (Singh *et al.* 2013). They state several well-rehearsed opinions and