19TLP0070_Singh

[PII]

Gold OA TBC

How to serve our ethnic minority communities better

Lancet Psychiatry 2019

On Jan 9, 2017, Theresa May, the British Prime Minister, gave a speech about "the burning injustice of mental illness", mentioning "injustices in the way black people with mental ill health in particular are treated", and promising that politicians would "take action to put things right."[1] In response to three decades of UK research on ethnic differences in mental health, such emotionally charged rhetoric has been commonplace, but has rarely produced meaningful change. Mental health care in ethnic minorities is complex, and needs dispassionate and objective scrutiny of evidence and its limitations, with careful disentanglement of the interactions between ethnicity, culture, community histories, legacies of racism, and the labyrinthine service structures that people with mental illness and their families must navigate to get appropriate help. In *The Lancet Psychiatry*, Phoebe Barnett and colleagues[2] present findings from a systematic review and meta-analysis of ethnicity and legal detention of people with mental illness, an impressive attempt at providing just such scrutiny. Although the findings are not strikingly different from what is known, this comprehensive paper is a timely reminder of how far we are from fully understanding the problem—let alone solving it—and why the stated political intention to put things right might be easy to promise but hard to deliver.

Barnett and colleagues[2] have updated previous similar reviews,[3,4] and expanded their data beyond the UK, including both ethnic minority and migrant populations. They report that black Caribbean patients (odds ratio 2·53, 95% CI 2·03–3·16, p<0·0001) and black African patients (2·27, 1·62–3·19, p<0·0001) were significantly more likely to be compulsorily admitted to hospital compared with those in white ethnic groups, as were south Asian patients, although to a lesser extent (1·33, 1·07–1·65, p=0·0091).[2] Migrant groups were also significantly more likely to be compulsorily admitted to hospital compared with native groups (1·50, 1·21–1·87, p=0·0003). Furthermore, black Caribbean patients were also significantly more likely to be readmitted to hospital compared with white ethnic groups (2·30, 1·22–4·34, p=0·0102). UK-based studies accounted for 69% of all published research included in this review, showing insufficient international attention. UK policy makers and providers have at least tried to understand and explore the problem, but the remaining studies are from only a handful of countries. The nature and magnitude of ethnic differences in detention remain unknown in large swathes of the world.

Barnett and colleagues[2] also explored explanations offered in the literature for ethnic differences in detention, and the evidence base for these explanations, replicating a similar attempt made more than a decade ago.[4] Regrettably, in the intervening years, our understanding of the reasons underlying these differences has not advanced. Almost half of the papers included in this review offered no explanations for ethnic variations, or offered explanations that lacked evidential support.[2] A substantial number of studies lacked methodological rigour and were of poor quality. The authors suggest that repeated assertion of untested explanations "might serve to entrench narratives of racial determinism"[2] rather than advance our understanding; this is a welcome suggestion since, at least in the UK, ideological assertions have often filled the gap when scientific evidence is absent. If this study[2] moves the debate beyond simplistic notions of institutional racism as the cause of all ethnic differences, it will have done a great service to patients and their families, since anything that drives a wedge of mistrust between people who need help and the services they need can only be counterproductive.[5] Misperceptions breed misattributions. In the ENRICH programme,[6] we found that for similar experiences of inadequate mental health care, white patients and families attributed poor care to bad service, whereas black patients and their carers considered services racist.

Barnett and colleagues[2] variously use the terms disproportionate, over-representation, and inequality to describe ethnic differences. Illnesses and their presentation, distribution, and outcomes are not equal. Epidemiology is based on group differences in prevalence and incidence, severity, and outcomes of illnesses. Serious mental illnesses such as schizophrenia are more prevalent in migrant and ethnic minority groups,[7] therefore so are the consequences of treating these disorders, including detention. Furthermore, ascribing notions of inequality to rates of detention presumes that legal detention is a bad outcome, and hence must be reduced. A better question is whether

detention is appropriate for the needs of a particular patient. Mental health legislation is almost always discussed as coercive and restrictive,[8] and it is indeed that.[9] But it is enabling too, allowing those who need mental health care to receive it when they are most in need.[10] Such reframing is not to minimise or ignore the potential for harm if mental health legislation does not have adequate checks and balances, or to diminish the negative effects of coercive encounters on patients and their carers. Appropriate mental health care will always need coercion in some cases. No legislative framework can obliterate the need for detention and compulsory treatment unless society is willing for some people to be abandoned to the ravages of their illness.

Barnett and colleagues[2] advise us to "avoid simple techniques to analyse complicated problems." The question of ethnic differences is not complicated, but complex. The difference between complicated and complex is not trivial or semantic, but profound and far reaching—it is a difference not just of degree, but of kind. Complicated systems can be understood by structural disaggregation into smaller parts and working out the relationship between the parts. By contrast, complex systems are primarily understood by their function. These systems are creative, dynamic, and fluid, ever changing because of feedback loops that influence the system itself and hence alter future outcomes. Complex systems are not reducible to smaller constitutive components, and the complexity of a system is not directly connected to the amount of data available.[11] The human body and human society are complex systems; changing one subsystem can have unpredictable consequences on the whole system. When faced with a complex problem, the temptation for politicians, policy makers, and academics is to treat it as if it were complicated, and then attempt to solve it simply with more data or resources.

How then should we solve the complex problem of ethnic differences in mental health care? We should certainly aim to provide easier access to better services, which offer choice, promote shared decision making, pay attention to cultural differences, and focus on therapeutic engagement. This aim is a moral, clinical, social, and humane imperative. But providing such care is not simply determined by resources, but by the quality of human interactions between service users and service providers. If services purposefully aim to build trust where there is mistrust, engender hope where there is despair, promote inclusion where there is marginalisation, and offer comfort where there is fear, we might better engage with the communities we serve. Compassionate, respectful, and dignity-oriented mental health care can generate positive feedback loops throughout the system, so that users experience care as therapeutic while clinicians find caring more rewarding. Such changes are hard to deliver, especially when clinicians feel stretched and ethnic minority service users feel frightened. More resources would certainly help, but the fundamental shift must be in the intangible and complex domains of attitudes and mutual perceptions.

Swaran P Singh

Division of Health Sciences, Mental Health and Wellbeing, Warwick Medical School, University of Warwick, Coventry CV4 7AL, UK

s.p.singh@warwick.ac.uk

I am a Commissioner for the UK Equality and Human Rights Commission.

1 Gov.uk. The shared society: Prime Minister's speech at the Charity Commission annual meeting. Jan 9, 2017. https://www.gov.uk/government/speeches/the-shared-society-prime-ministers-speech-at-the-charity-commission-annual-meeting (accessed Jan 22, 2019).

2 Barnett P, Mackay E, Matthews H, et al. Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *Lancet Psychiatry*2019; published online XX. **[Prod: Linked reference. Please check and add details before publication.]**

3 Bhui K, Stansfeld S, Hull S, Priebe S, Mole F, Feder G. Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *Br J Psychiatry* 2003; **182:** 105–16.

4 Singh SP, Greenwood N, White S, Churchill R. Ethnicity and the Mental Health Act 1983. *Br J Psychiatry* 2007; **191:** 99–105.

5 Singh SP, Burns T. Race and mental health: there is more to race than racism. *BMJ* 2006; **333:** 648.

6 Singh SP, Islam Z, Brown LJ, et al. Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. Southampton: NIHR Journals Library, 2013.

7 Mcgrath J, Saha S, Chant D, Welham J. Schizophrenia: a concise overview of incidence, prevalence, and mortality. *Epidemiol Rev* 2008; **30:** 67–76.

8 Gooding P, McSherry B. Alternatives to compulsory detention and treatment and coercive practices in mental health settings. *J Law Med* 2018; **26:** 300–05.

9 Nyttingnes O, Ruud T, Rugkåsa J. 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. *Int J Law Psychiatry* 2016; **49:** 147–53.

10 Lamb S, Cresci E. The day the NHS saved my life: I was sectioned after trying to kill myself. Jan 26, 2016. https://www.theguardian.com/society/2016/jan/26/nhs-saved-my-life-sectioned-after-tried-to-kill-myself (accessed Feb 4, 2019).

11 Poli R. A note on the difference between complicated and complex social systems. *Cadmus* 2013; **2:** 142–47.