Evidence briefing on the drivers of racial disparities in the Mental Health Act

Background

This briefing note summarises evidence about the drivers of racial disparities in the Mental Health Act (MHA), specifically overrepresentation of minoritised ethnic groups, particularly Black individuals, in compulsory admissions and issuances of Community Treatment Orders (CTOs). Understanding these disparities is crucial for improving mental health care, tackling health inequalities and ensuring use of the MHA is appropriate.

This paper was produced at pace to support engagement for the Mental Health Bill as it is considered by Parliament. It is not a systematic review of literature but is intended to give a summary of our current understanding and existing work to address these issues.

Data and Key Metrics

Use of the Mental Health Act:

Annual statistics on detention rates and CTO rates are published by NHS England as part of their annual Mental Health Act Statistics and are reported by ethnic groups.[1]

In 2023/24 Black or Black British detention rates were over three and a half times higher than that of the White British group.[1] This ratio has been broadly stable since 2017/18 (from 2017/18 to 2023/24). Mixed and Asian ethnic groups also experience elevated rates of detention, though to a lesser extent.

- Black or Black British people have longer periods of detention and more repeated admissions[2] and are also more likely to be subject to police holding powers under the Mental Health Act.[3]
- In 2023/24, Black or Black British people were issued with Community Treatment Orders at 7 times the rate of White or White British people.[Error! Bookmark not defined.] This disparity was highest in 2021/22, where Black or Black British people had a standardised Community Treatment Order rate which was 11 times those of White or White British people. Racial disparities have improved in recent years and returned to pre-pandemic levels; however, we do not have any evidence as to why they have improved, but still remain evident.

Prevalence of mental disorders across ethnic groups:

The Adult Psychiatric Morbidity Survey (APMS) series provides robust nationally representative data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over). The results of analysis by ethnic group should be treated with caution as sample sizes may be limited. The 2014 APMS[4] (most recent available data) estimated:

- Prevalence of common mental disorders (depression, phobia, OCD, panic attacks) did not vary by ethnicity for men. However, it did for women: White non-British women were less likely than White British women to have a common mental disorder (15.6% vs 20.9%). Symptoms of common mental disorder were most common in Black and Black-British women (29.3%).
- Prevalence rate of psychotic disorder was higher in Black men (3.2%) than any other ethnic group: 0.3% of White men, 1.3% of Asian men and no cases observed in mixed / other ethnic group

[1] Mental Health Act Statistics, Annual Figures - NHS England Digital
[2] NHS Digital Mental Health Act Statistics, Annual Figures 2023/24: Table 1c, 3c.
[3] Monitoring the Mental Health Act in 2020/21 - Care Quality Commission (cqc.org.uk)
[4] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. - NHS England Digital

- Age standardised rate of trauma in adulthood did not vary by ethnicity. However, variation in screening positive for PTSD by ethnic group approached, but did not reach significance: 8.3% of Black/Black-British adults versus 4.2% of White-British adults.
- No significant variation was found by ethnic group in personality disorder, bipolar disorder or suicidal thoughts, suicide attempts and self-harm.

An update to the APMS is due for publication in July 2025 (fieldwork 2023). This will aim to provide ethnicity breakdowns (5 ethnic groups) across conditions where possible but may be limited by sample size.

People from South Asian, non-British White and mixed ethnicity groups are also at increased risk of severe mental illness compared to White British people.[5] International evidence also finds that people from come minoritised ethnic groups in White majority countries are at elevated risk of psychosis, but that this risk varies across ethnic groups. Moreover, research suggests that the rate of psychiatric morbidity for ethnic minorities is different than in countries where those groups are the ethnic majority.[6]

Further research is needed to understand the drivers of observed differences in prevalence of mental health disorders across ethnic groups.

Data improvements

NHS England is working with local mental health systems to embed metrics to improve their local data on access, experience and outcomes for Black, Asian and minority ethnic communities. Broadening the data available and improving data quality are intended to advance equalities in mental health – facilitating better performance monitoring, understanding of current disparities and designing appropriate service improvements.

NHS England's Patient and Carer Race Equality Framework (PCREF) (published in October 2023)[7] is the first ever anti-racism framework which is mandatory for all mental health service providers to embed across England from March 2025 as aligned to NHS Standards Contract 2024/25, ensuring they are responsible for implementing concrete actions to reduce racial inequality within their services. It will become part of CQC's and EHRC's inspection processes and 13 Pilot Trusts have already started to implement targeted changes in areas such as governance, data collection, staff training and community engagement to shift the dial on cultural awareness and ensure transparency. The PCREF team will support on a new dataset on improvements in reducing health inequalities, as well as improving details on ethnicity in all existing core data sets.

NHS England are working on improvements to the Mental Health Services Data Set (MHSDS), including development of the Mental Health Act dashboard to ensure it is easier to use, data is captured in one place, and allows users to readily monitor the Act. The dashboard will shift to include both annual and monthly statistics, to provide more timely data for monitoring purposes along with breakdowns for protected characteristics. NHS England are also reviewing other mental health data products to understand what improvements are needed for better inequalities monitoring in the future.

Currently we do not have any data on the number of referrals made to AMHPs for Mental Health Act assessments. We know there is over-representation of black groups in detention rates, but we do not know if that stems from overrepresentation in referrals. DHSC has commissioned ADASS and LGA to collect a pilot data set on referrals to AMHPs. This data set was collected over three continuous months,

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[5]Halvorsrud, K, Nazroo, J, Otis, M, Brown Hajdukova, E & Bhui, K 2019, 'Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses', Social psychiatry and psychiatric epidemiology, vol. 54, no. 11, pp. 1311-1323.

[6] Jongsma, H. E., Karlsen, S., Kirkbride, J. B., & Jones, P. B. (2021). Understanding the excess psychosis risk in ethnic minorities: the impact of structure and identity. *Social psychiatry and psychiatric epidemiology*, *56*(11), 1913-1921. Available at: https://link.springer.com/article/10.1007/s00127-021-02042-8

[7] *Patient and carer race equality framework*. *NHS England*. Available at: https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/#.

starting mid-September 2024 with the first submission 4 weeks later. The pilot data set will include how many referrals are made, what the outcome of the referral was (detention or other decision), and the ethnicity of those referred, to start to give some insight into if there are any disparities in initial referrals, and whether that explains any of the disparities in detention rates.

Remaining data gaps

Prevalence survey data is limited by sampling constraints, which mean breakdowns are only available only wide ethnic groupings, and the potential for analysis of intersectionality and sub-populations is limited. Another limitation of prevalence survey data is its timeliness, with surveys taking years to deliver and report.

Nationally, people who have used community mental health services are surveyed annually by CQC to capture their experience of care, but mental health inpatients are excluded from the annual adult inpatient survey.[8]**Error! Bookmark not defined.** The lack of robust data on the experiences of patients is a significant gap in our understanding of mental health services, and of potential inequalities. Planned work to improve this in NHSE include the PCREF patient and carer feedback mechanism, this will ensure patient experience data is used, monitored and flowed to national data-sets.[9]

Until recently there have been no national level administrative data linkages including mental health services data available for research use, limiting analysis of factors and experiences across other systems that might contribute to risk of detention under the Mental Health Act. There is potential for newly available linkages such as the Extended E-child dataset linking education and health data[10], as well as potential future linkages, to advance the evidence base.

Research into racial disparities in mental health care and treatment

Existing research

The Independent Review[11] heard that mental health services often fail to meet the needs of minority groups, as they lack the cultural competence to understand different beliefs, backgrounds, and experiences. This can prevent individuals from accessing support before reaching a crisis point, increasing the likelihood of detention. A lack of awareness or appreciation of religious and spiritual beliefs can further impact assessment and detention experiences under the MHA.

A separate literature and evidence review of racial disparities in mental health[12] commissioned by NHS England, highlights inequalities faced by Black and minority ethnic communities in accessing and receiving mental health care. Findings were that Black and minority ethnic individuals are at higher risk of mental illness, more likely to enter services through crisis care or the criminal justice system, and often face biases in assessment and treatment, leading to poorer outcomes. The review also highlights examples of projects and approaches that work across these issues, such as community-led initiatives that improve access, trust, and culturally appropriate mental health support.

A rapid review of evidence on ethnic inequalities in healthcare undertaken for the NHS Race and Health Observatory[13] identified multiple barriers preventing ethnic minority groups from seeking and accessing

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[8] Further information is available at: https https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-data

[9] *Patient and carer race equality framework*. *NHS England*. Available at: https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/#.

[10] Further information is available at: https://gtr.ukri.org/projects?ref=ES%2FX003663%2F1

[11] Independent Review of the mental health act 1983 (Published 6 December 2018). Available at: https://assets.publishing.service.gov.uk/media/5c6596e140f0b676df6e4746/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf.

[12] Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health. *Race Equality Foundation*.

[13] Kapadia, D. et al. (2022) 'Ethnic inequalities in healthcare: a rapid review of the evidence', *NHS Race and Health Observatory*. Available at: https://www.nhsrho.org/research/ethnic-inequalities-in-healthcare-a-rapid-evidence-review-3/

treatment for common mental disorders, linked to a distrust of health care providers and fear of being discriminated against. Qualitative research, identified in this review, also highlights the lack of appropriate interpreting services as a deterrent to seeking help. Additionally, the review found significant gaps in access to secondary treatment for severe mental illness, along with poorer recovery outcomes. It also found that people from Black Caribbean, Black African, and Black British backgrounds with severe mental illness experience higher rates of contact with the police and criminal justice system, both as victims and offenders.

Other research in this area highlights key factors contributing to higher detention rates among minoritised ethnic groups, particularly Black people, including barriers to initial access and lower likelihood of receiving evidence- based treatments.

- Barriers to initial access – many individuals face difficulties in accessing mental health services due to a lack of information, cultural differences in understanding mental illness, and how services respond to first contact (Bhui, 2002[14]; Ghali et al., 2013[15]; Cooper et al., 2013[16]). Some evidence suggests that access may be improving (Oduola et al., 2019).[17]
- Lower likelihood of receiving evidence-based treatments – even when accessing services, people from minoritised backgrounds are less likely to receive evidence-based interventions (Das Munshi et al., 2018[18]; Schlief et al., 2023[19]). This may be influenced by engagement challenges, cultural perceptions of treatment, or unconscious bias among mental health professionals.

Ongoing research and upcoming publications

Through the National Institute for Health and Care Research (NIHR) Policy Research Programme, DHSC commissioned four research studies in response to the recommendations from the Independent Review of the MHA published in 2018. These studies have now completed with findings due to be published in the coming months. The first two studies were explicitly focussed on understanding and addressing racial inequalities in the application of and/or outcomes under the Mental Health Act.

1. Experience-based investigation and codesign of approaches to prevent and reduce Mental Health Act use (CO-PACT)[20]
    - A study aimed at understanding and addressing the disproportionate use of the MHA among racialised communities in England.
2. Improving the Experiences of Black African Caribbean Men Detained Under the Mental Health Act: A Co-Produced Intervention Using the Silences Framework (ImprovE-ACT)[21]
    - A study aimed at enhancing the experiences of Black African and Caribbean men who have been detained under the Mental Health Act in the UK.
3. One-to-one Peer support for family members and friends of patients treated under the Mental Health Act (OPAL)[22]

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[14] Bhui, K. (Ed.). (2002). Racism and mental health: Prejudice and suffering. Jessica Kingsley Publishers.
[15] Ghali S, Fisher HL, Joyce J, Major B, Hobbs L, Soni S, et al. Ethnic variations in pathways into early intervention services for psychosis. Br J Psychiatry 2013; 202: 277–83
[16] Cooper C, Spiers N, Livingston G, Jenkins R, Meltzer H, Brugha T, McManus S, Weich S, Bebbington P. Ethnic inequalities in the use of health services for common mental disorders in England. Soc Psychiatry Psychiatr Epidemiol. 2013 May;48(5):685-92. doi: 10.1007/s00127-012-0565-y. Epub 2012 Aug 15. PMID: 22893107.
[17] Oduola S, Craig TKJ, Das-Munshi J, Bourque F, Gayer-Anderson C, Morgan C. Compulsory admission at first presentation to services for psychosis: does ethnicity still matter? Findings from two population-based studies of first episode psychosis. Soc Psychiatry Psychiatr Epidemiol. 2019 Jul;54(7):871-881. doi: 10.1007/s00127-019-01685-y. Epub 2019 Mar 20. PMID: 30895353; PMCID: PMC6656788.
[18] Das-Munshi, J., Bhugra, D. & Crawford, M.J. Ethnic minority inequalities in access to treatments for schizophrenia and schizoaffective disorders: findings from a nationally representative cross-sectional study. BMC Med 16, 55 (2018). https://doi.org/10.1186/s12916-018-1035-5
[19] Schlief, M. *et al.* (2023) 'Ethnic differences in receipt of psychological interventions in early intervention in psychosis services in England – a cross-sectional study', *Psychiatry Research*, 330, p. 115529. doi:10.1016/j.psychres.2023.115529.
[20] Further information can be found at https://fundingawards.nihr.ac.uk/award/NIHR201704
[21] Further information can be found at https://fundingawards.nihr.ac.uk/award/NIHR201715
[22] Further information can be found at https://fundingawards.nihr.ac.uk/award/NIHR201707

- A study aimed at developing and implementing a peer support program for informal carers—family members, partners, or friends—of individuals detained under the Mental Health Act (MHA) in England.

4. Development, Feasibility Testing and Pilot Trial of a Crisis Planning and Monitoring Intervention to Reduce Compulsory Hospital Readmissions (the FINCH Study)[23]:
    - A study aimed at evaluating whether an intervention to prevent compulsory readmission can be developed that is acceptable to people who have recently been compulsorily admitted (including Black and Black British people).

DHSC have more recently commissioned the NIHR Mental Health Policy Research Unit to conduct a new project on mental health crisis care, which is ongoing.[24] This involves:

- A national mapping of acute and crisis care arrangements for people presenting in mental health crisis in England,
- An exploration, of the success of crisis care arrangements in delivering flexible and effective crisis responses,
- An investigation of the relationship between crisis care arrangements and inpatient psychiatric admissions.

DHSC have also commissioned pilots to develop models for delivering culturally appropriate advocacy (CAA) for people from ethnic minority backgrounds who access mental health services. The first phase of piloting ran from November 2021 to June 2022 and tested various models of CAA in three areas of England. An independent evaluation recommended further testing to develop understanding, and Phase 2 of the pilots will run until March 2025. The final evaluation will inform the development of a framework for commissioning and delivering CAA.

Key research gaps

As discussed above, further research is needed to understand why observed disparities exist. Existing literature suggests a number of potential (and interrelated) factors may be relevant including (but not limited to) discrimination, ethnic bias, prevalence or barriers to engagement with services, cultural factors and wider inequalities.[25]

Another related priority for further work is understanding of how to reduce observed disparities, including evaluation of initiatives that could contribute to reduced rates of crisis and detention. The studies discussed in the above section will contribute to addressing this evidence gap, as will planned evaluation of MHA reforms. DHSC works with the NIHR and other stakeholders on an ongoing basis to develop the evidence base.

A further priority is to build understanding of the extent to which learnings from research are being effectively implemented at all levels of commissioning and practice to improve care, and how this can be supported.

Evaluation of Mental Health Act reforms

We plan to commission an independent evaluation of the reforms. It is expected that evaluating and monitoring the reforms will need to be a long term, staged exercise given the long period over which different reforms are expected to be sequentially commenced following initial primary legislation.

The evaluation will aim to understand how in practice the reforms established by legislation are implemented and how far they are likely to achieve the intended outcomes for patients. It will be

[23] Further information can be found at https://fundingawards.nihr.ac.uk/award/NIHR201739

[24] Further information can be found at https://www.ucl.ac.uk/psychiatry/research/nihr-mental-health-policy-research-unit/mhpru-2-projects

[25] Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). Racial disparities in mental health. *Race Equality Foundation*.

important to assess whether new safeguards and support mechanisms are being equitably accessed, considering race, disabilities, age, gender and socioeconomic factors. Research questions may include:

- Has patient and carer experience under the Mental Health Act improved?
- Has uptake of advocacy increased?
- Have racial disparities in outcomes under the Mental Health Act decreased?

We would expect the evaluation to use a range of quantitative and qualitative approaches, such as collecting and comparing data on detention rates, service usage and health outcomes for ethnic minorities before and after the implementation of the Act, and interviews and focus groups to gather personal experiences and perceptions of care. Additionally, there may be the opportunity to engage with community organisations representing ethnic minorities and advocacy groups for individuals with a learning disability and autistic people to gain insights into the impact of the Act and to inform the evaluation process.

Any independent evaluation would be subject to the availability of funding and to receipt of fundable research application(s). Applications are subject to peer review and judged in open competition, with awards being made on the basis of the importance of the topic to patients and health and care services, value for money and scientific quality.