Access and Experience of Mental Health Crisis Care Services in Leeds by Black and Minority Ethnic Communities

Report of phase 1

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1. Summary

As part of the Leeds Crisis Care Concordat Action Plan for 2016/17, we have compiled some evidence about the experiences and patterns of use of the Leeds crisis care pathways by black and minority ethnic (BME) communities.

To do this we reviewed data recorded by the statutory crisis services, and data and reports by Dial House @ Touchstone and by Positive Action for Refugees and Asylum Seekers, two third sector organisations.

Conclusions

Third sector organisations as well as statutory services are supporting people from black and minority ethnic communities to access help when they reach crisis point.

Dial House @ Touchstone, a specific BME crisis service which opened in October 2013, changed their service model and their use of language and recruited staff from minority groups. These changes, and other learning, resulted in a significant increase in the number of clients seen who were from BME communities.

We found significant differences in the levels of use of NHS secondary crisis services in Leeds between ethnic groups, summarised in the table below.

<table>
<thead>
<tr>
<th>Use of NHS Crisis services in Leeds* 2013-2016</th>
<th>All face-to-face</th>
<th>Intensive Community Services</th>
<th>Admitted to a mental health ward</th>
<th>Detained under the Mental Health Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>17% lower than white British</td>
<td>50% higher than white British</td>
<td>90% higher than white British</td>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
<td>50% higher than white British</td>
<td>150% higher than white British</td>
<td>240% higher than white British</td>
<td></td>
</tr>
<tr>
<td>Mixed heritage</td>
<td>60% higher than white British</td>
<td>140% higher than white British</td>
<td>190% higher than white British</td>
<td></td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>40% higher than white British</td>
<td>100% higher than white British</td>
<td>140% higher than white British</td>
<td></td>
</tr>
<tr>
<td>White Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The table only shows significant differences in the levels of use of crisis services
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There were some gaps in ethnicity recording by services, especially in community services.

Emerging next steps / recommendations:

1. Scope establishing a time-limited city-wide multi-agency group
2. Literature review of evidenced-based good practice
3. Hold a stakeholder event to identify actions: LYPFT-specific & city-wide actions which:
   - have clarity of purpose(s)
   - are action-oriented: co-produced- pilot and evaluate solutions
   - sustained action over several years
   - are sponsored/supported by Senior Champions.

We also identified options for finding out more.

2. Introduction

This is a report of work on the Leeds Crisis Care Concordat Action Plan for 2016/17. As a first step to improve understanding of experiences of the Leeds crisis care pathways by black and minority ethnic (BME) communities we present here some quantitative evidence.

The purpose of this work is to improve the experience of the Leeds crisis pathway by black and minority ethnic communities.

3. Questions

In response to the Leeds Crisis Care Concordat action plan we wanted to address three questions:

1. How do people from black and minority ethnic (BME) communities access help when they or somebody they care for reaches crisis point?
2. What happens when people from BME communities ask for help?
3. Are there any differences in the levels or patterns of access to secondary mental health crisis services between BME communities and the White British population?

In this first phase of work we have explored what data is available to address these questions. This is presented in the next section.
4. Previous Research

Published research\(^1\) and national data\(^2\) suggest that some groups of people are more likely to reach crisis point before accessing services and tend to access non-health-related services when in crisis. This is particularly true for some black, minority ethnic and refugee communities.

UK figures\(^2,3\) also suggest that some black and minority ethnic groups are detained more frequently under the Mental Health Act.

The National Census\(^4\) in 2011 reported that out of a total population of 751,000 people living in Leeds (all ages):

- 142,000 people (19%) were from black and minority ethnic (BME) communities, with the remaining
- 610,000 (81%) identifying as white British.
- Total adults aged 16-64 living in Leeds: 40,000 Asian / Asian British, 18,000 Black or Black British, 11,000 Mixed, 407,000 White British, 22,000 Other White, and 6,000 from Other Ethnic groups, rounded to the nearest thousand.

Last autumn, the national 2014 Adult Psychiatric Morbidity survey [reference 10] reported that:

- Psychotic disorder affected 1 adult in 140. The rate was found to be higher among black and black British men, at about 3 men in 100.
- 1 adult in 50 screened positive for bipolar disorder. The rate of bipolar disorder did not vary by ethnic group.
- Only 7% people from black and minority ethnic communities said they were receiving treatment for a mental health problem, while 13% of white British people said they were receiving treatment for a mental health problem, either medication, or talking therapy, or both. People in the Black / Black British ethnic group had particularly low treatment rates (chart 0), after controlling for other factors using modelling. People from other minority ethnic communities also had lower treatment rates than white British people (chart 0). The same pattern was found in the 2007 survey.
During 2014, the survey interviewed 7,500 people aged 16 and over, across England about their mental health, wellbeing and treatment. The people interviewed were a representative sample of the whole population of England who were living at home.

5. Scope and data

5.1 Some data presented is from Leeds and York Partnership NHS Foundation Trust (LYPFT). The data covers the three financial years from April 2013 to March 2016, and includes:

- All adults aged 16-64 at referral or admission who were
- Commissioned by Leeds NHS Clinical Commissioning Groups (Leeds CCGs).

The crisis services included are:

- ALPS
- SPA/SPUR, which includes the Crisis Assessment Service (CAS)
- Intensive Community Services (ICS), including the patients seen by all three ICS locality teams: ENE, SSE, and WNW.

We only included service users who had a successful face-to-face contact with these services.

The following acute inpatient services are also included:

- Becklin, wards 1, 3, 4, 5
- Newsam 1 (PICU)
- Newsam 4
- CAU (Clinical Assessment Unit, opened 2015/16)

Not in scope: specialist services, including forensics, and eating disorders.

In this report we have used the ethnicity categories used by the Office for National Statistics in the 2011 National Census\(^5\), which are shown in appendix 1. The current
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NHS data model is the one used in the 2001 National Census. The differences relevant to this report are:

- Chinese is included under the Asian or Asian British category in this report
- In this report “White Other” includes White Irish, White Gypsy or Irish Traveller, and Any Other White Background.

The LYPFT patient data system, PARIS, uses the categories in the current NHS data model.

5.2 Some data from Dial House @ Touchstone, and from PAFRAS is also presented in this report.

6. Data Analysis

6.1 Question 1: How do people from black and minority ethnic (BME) communities access help when they or somebody they care for reaches crisis point?

We have only found limited evidence about this question.

We analysed data about the source of referrals to the Crisis Assessment Service (CAS), including Mental Health triage, section 136, and Other CAS referrals. We reviewed referrals from GPs, from the Police, and self-referrals.

- From table 1 it can be seen that 18% of the referrals made by the police and by GPs were of people from black and minority ethnic (BME) communities. This level is very similar to the fraction of the total population of Leeds which identified as black or another minority ethnicity at the 2011 national census.
- The fraction of self-referrals made by people from BME communities was a bit lower, at 14%.
- The service user’s ethnicity was missing from 23% of these referral records (23% missing in 2013/14, 22% missing in 2014/15, 24% missing in 2015/16).

Table 1: % People referred to the Crisis Assessment Service who were from black and minority ethnic (BME) communities

<table>
<thead>
<tr>
<th>Distinct Patients</th>
<th>Source</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Triage referrals</td>
<td>Police</td>
<td>19%</td>
<td>17%</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Other CAS referrals</td>
<td>GP</td>
<td>20%</td>
<td>21%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Other CAS referrals</td>
<td>Self</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Section 136 referrals</td>
<td>Police</td>
<td>18%</td>
<td>18%</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Leeds total population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19% BME</td>
</tr>
</tbody>
</table>

16 Nov 2017
Leeds Survivor-Led Crisis Service run Dial House @ Touchstone, a specific BME crisis service.

Table 2: How new visitors heard about Dial House @ Touchstone, Sep 15 - Aug 16

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>No.</th>
<th>Referral Source</th>
<th>No.</th>
<th>Referral Source</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solace</td>
<td>10</td>
<td>Psychiatric serv.</td>
<td>2</td>
<td>Internet</td>
<td>1</td>
</tr>
<tr>
<td>Crisis Team</td>
<td>4</td>
<td>Support Worker</td>
<td>2</td>
<td>One stop</td>
<td>1</td>
</tr>
<tr>
<td>Friend</td>
<td>3</td>
<td>111</td>
<td>1</td>
<td>Police</td>
<td>1</td>
</tr>
<tr>
<td>Barca</td>
<td>2</td>
<td>Aire Court</td>
<td>1</td>
<td>Red Cross</td>
<td>1</td>
</tr>
<tr>
<td>G.P.</td>
<td>2</td>
<td>College</td>
<td>1</td>
<td>Women’s Aid</td>
<td>1</td>
</tr>
<tr>
<td>Pafras</td>
<td>2</td>
<td>G4S Accommod.</td>
<td>1</td>
<td>Not stated</td>
<td>2</td>
</tr>
</tbody>
</table>

Most people are sign-posted to Dial House @ Touchstone by third sector services, particularly those supporting refugees and asylum seekers (table 2 above). In contrast, the most common way visitors get sign-posted to Dial House is by the statutory crisis team. Leeds Survivor-Led Crisis Service commented that this difference probably reflects the unwillingness of people from BME groups to access statutory mental health services.

Refugees & Asylum Seekers: during 2016, the mental health assessment worker at PAFRAS (Positive Action for Refugees and Asylum Seekers) handled 16 crisis situations at their weekly drop-in sessions.

6.2 Question 2: What happens when people from BME communities ask for help?

We have only found limited evidence about this question.

Evidence presented under question 3 below shows that when adults from BME communities do see an NHS crisis service, they are more likely to be admitted to a mental health ward, and more likely to be detained under the mental health act than people from white British communities.

Leeds Survivor-Led Crisis Service run Dial House @ Touchstone, a specific BME crisis service.

- For the past two years, Dial House @ Touchstone have learned through the feedback which they obtained during the reviews how difficult it can be for (BME) visitors to gain trust and form a therapeutic relationship with their Crisis Support Workers. They recognised that the Dial House model of all staff
supporting all visitors was not working for BME visitors, where trust is harder to win.

- Responding to that, Dial House @ Touchstone have introduced a six session support model where the visitor can see the same worker for the first six sessions. This gives the visitor more time to explore his/her crisis, build a relationship based on trust and develop an effective support plan. This has enabled visitors to build trust with Dial House @ Touchstone. After the six sessions, visitors are more likely to engage with the service and other team members.

Positive Action for Refugees and Asylum Seekers (PAFRAS): the mental health assessment worker had used a range of responses according to level of risk of harm to self or others, including: de-escalation strategies, co-operation with GP / Solace / Social Services / WY-Fi, Dial House, Community Mental Health Team, Single Point of Access (SPA), mental health assessment at A&E, admission to Intensive Community Services. The mental health assessment worker had written up two case studies of crisis situations they had dealt with, summarised below:

- Called the mental health crisis team; referred to social services; mental health assessment at A&E; temporary accommodation by social services; Red Cross caseworker; referred to York Street Homeless Practice; referred to Forward Leeds.

- Individual had taken a second overdose; taken by friends to A&E; admitted to Intensive Community Services; ongoing support by PAFRAS mental health assessment worker.

6.3 Question 3: Are there any differences in the levels or patterns of access to secondary mental health crisis services between BME communities and the White British population?

We looked at four crisis services and all detentions:

- All face-to-face contacts by ALPS, SPA/SPUR (6.3.1)
- Admissions to a mental health ward (6.3.2)
- Intensive community services (6.3.3)
- Detentions under the Mental Health Act (6.3.4)
- Dial House @ Touchstone (6.3.5)

For the first four of these we found out how many different adults had used that service over a three-year period in each ethnic group. Then we calculated the fraction of adults in each ethnic group who had used that service over the three year period using the total adults living in Leeds who identified in that ethnic group at the 2011 national census.
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6.3.1 All face-to-face contacts (including admissions)

Between April 2013 and March 2016, ALPS, SPA/SPUR and inpatient wards saw 9882 different adults aged 16-64 under a service commissioned by the Leeds NHS Clinical Commissioning Groups. Of these, 6228 identified as white British, 1494 identified as BME, 38 preferred not to say their ethnicity, and ethnicity was missing for 2122 people. Out of those people whose ethnicity was recorded, 19% identified as BME. Service users are only counted once even if they were referred several times or were seen by more than one service.

Chart 1 shows how many Leeds adults aged 16 to 64 had at least one face-to-face contact (or admission) with NHS mental health crisis services per 1,000 population per year in Leeds by each ethnic category between April 2013 and March 2016.

![Chart showing face-to-face contacts per 1,000 population by ethnic category]

We arrived at these figures by calculating for 2013 to 2016 for each ethnic category:

Total distinct adults aged 16-64 seen during the period by NHS crisis services in Leeds
Total population of the same ethnic category in Leeds aged 16-64

Chart 2 shows the 95% confidence intervals on the fractions of the population of Leeds adults seen by an NHS crisis service at least once between April 2013 and March 2016. We can be 95% confident that the underlying level of risk lies between these confidence limits. The method used to calculate the confidence intervals is described in appendix 2.
Observations:

- 8.0 Adults who identified as mixed per 1000 population per year had one or more contacts with crisis services. We can be 95% confident that the population risk lies between 7.0 and 8.9.
- 5.1 Adults who identified as white British per 1000 population per year had one or more contacts with crisis services. We can be 95% confident that the population risk lies between 5.0 and 5.2.
- Hence adults who identify as mixed heritage were 56% more likely to use a mental health crisis service than the white British population. This difference is statistically significant at 95% confidence.
- Among the Asian / Asian British population, the contact rate was 17% lower than the White British population. This includes people who identified as Chinese. This difference is statistically significant at 95% confidence.
- In the black / black-British, the white-other, and the other-ethnic-groups populations, the contact rates were not significantly different from the contact rate for the white British population, at 95% confidence, since the confidence intervals overlapped with those for white British.

However, for 21% of the adults aged 16 to 64 seen over this three-year period, the ethnicity was missing from the electronic patient record (chart 3). If the recording of ethnicity had been more complete, we might have found different patterns of service use.
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Chart 3 Leeds adults seen in Leeds for crisis care April 2013 to March 2016

In chart 3, those service users with ethnicity 'not stated' are included as having a valid ethnicity recorded, as service users are free not to say how they identify their ethnicity. Patient records where the ethnicity was recorded as 'no data' or as 'not known' are shown as 'missing' on chart 3.

During 2015/16, the % distinct service users with ethnicity missing was:
- 9% adults seen by the Acute Liaison Psychiatry team
- 27% adults seen by SPA or SPUR

6.3.2 Admissions

Between April 2013 and March 2016, 1829 different adults aged 16-64 were admitted to an NHS mental health ward under a service commissioned by the Leeds NHS Clinical Commissioning Groups. Of these, 1216 identified as white British, 510 identified as BME, 13 preferred not to say their ethnicity, and ethnicity was missing for 90 people. Out of those people whose ethnicity was recorded, 30% identified as BME.

Service users are only counted once even if they were admitted several times or were seen by more than one service during the period. Only Leeds-commissioned adults were included.

Chart 4 shows how many Leeds adults aged 16 to 64 were admitted to an NHS mental health ward at least once per 1000 population per year in Leeds by each ethnic category between April 2013 and March 2016.
We arrived at these figures by calculating for 2013 to 2016 for each ethnic category:

Total distinct Leeds adults aged 16-64 admitted to a ward in Leeds during the period
Total population of the same ethnic category in Leeds aged 16-64

Chart 5 shows the 95% confidence intervals on the fractions of the population of Leeds adults admitted to a mental health ward at least once between April 2013 and March 2016. We can be 95% confident that the underlying level of risk lies between these limits. The method used to calculate the confidence intervals is described in appendix 2.
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Observations:

- 2.5 Adults who identified as black or black British per 1000 population per year were admitted to a mental health ward one or more times during the period. We can be 95% confident that the population risk lies between 2.1 and 2.9.

- 1.0 Adults who identified as white British per 1000 population per year were admitted to a mental health ward one or more times during the period. We can be 95% confident that the population risk lies between 0.9 and 1.1.

- Hence adults who identify as black or black British were 150% more likely to be admitted to a mental health ward than the white British population. This difference is statistically significant at 95% confidence.

- A significantly higher fraction of adults in every BME category except white non-British had been admitted to a mental health ward than adults in the White British population:
  - Asian or Asian British, 50% higher than White British
  - Black or Black British, 150% higher
  - Mixed, 140% higher
  - Other Ethnic Groups, 100% higher

At the Urgent and Crisis Care meeting we were asked if the variation between ethnic communities could be explained by differences in the demography (age and gender) of the different BME communities. We investigated this by:

- Calculating the expected number of people who would have spent time in hospital for each Leeds BME community if the England 2015/16 age- and gender-specific rates were applied to that community. We took the England rates from table 2.2 of the Mental Health Bulletin: 2015/16 Annual Report published by NHS Digital [reference 8].

- We compared the actual number of different Leeds people who had spent time in hospital during 2013-16 with the expected number of people for each ethnic category (if the England age- and sex-specific rates had applied: this is indirect standardisation).

- We then calculated 95% confidence intervals to find out which differences were significant, as described in appendix 2 [reference 9]. The results are shown in chart 6 and table 3, and are similar to the results described above.
About 90 more people were admitted each year than the number of people expected to be admitted if everybody was White British: that is 12% of the total number of different people who were admitted each year on average (741).

Out of everybody seen for 1 or more crisis assessments over the 3 years:
- 45% of the Black people were admitted one or more times
- Around 1 in 3 of the Asian, mixed and other ethnic groups were admitted
- Compared to 1 in 5 among the White British people (chart 7).

The service user’s ethnicity was recorded for 95% of the adults aged 16-64 admitted to a mental health ward over this three-year period (chart 8).
Chart 8 Leeds adults aged 16 to 64 admitted to a mental health ward in Leeds from April 2013 to March 2016

In chart 8, those service users with ethnicity ‘not stated’ are included as having a valid ethnicity recorded, as service users are free not to say how they identify their ethnicity. Patient records where the ethnicity was recorded as ‘no data’ or as ‘not known’, are shown as ‘missing’ on chart 8.

6.3.3 Intensive Community Services, ICS

Intensive Community Services (ICS) are provided via the three locality team bases and offer a mix of home visiting and unit-based acute treatment. The services offer flexibility and are provided based on the service user’s choice. The ICS provide an alternative to hospital admission.

Between April 2013 and March 2016 Intensive Community Services saw 3914 different adults aged 16-64 under a service commissioned by the Leeds NHS Clinical Commissioning Groups. Of these, 2709 identified as white British, 744 identified as BME, 21 preferred not to say their ethnicity, and ethnicity was missing for 440 people. Out of those people whose ethnicity was recorded, 22% identified as BME.

Service users are only counted once even if they were referred several times or were seen by more than one service. Only Leeds-commissioned adults were included.
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Chart 9 shows how many Leeds adults aged 16 to 64 had at least one face-to-face contact with an intensive community service per 1,000 population per year by each ethnic category between April 2013 and March 2016.

<table>
<thead>
<tr>
<th>Ethnic Category</th>
<th>Average Number of Distinct ICS Patients per 1,000 Population per Year, Leeds 2013-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian British</td>
<td>2.2</td>
</tr>
<tr>
<td>Black British</td>
<td>3.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.6</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>3.2</td>
</tr>
<tr>
<td>White Other</td>
<td>1.9</td>
</tr>
<tr>
<td>White British</td>
<td>2.2</td>
</tr>
</tbody>
</table>

We arrived at these figures by calculating for 2013 to 2016 for each ethnic category:

- **Total distinct adults aged 16-64 seen during the period by ICS in Leeds**
- **Total population of the same ethnic category in Leeds aged 16-64**

Chart 10 shows the 95% confidence intervals on the fractions of the population of Leeds adults seen by intensive community services at least once between April 2013 and March 2016. We can be 95% confident that the underlying level of risk lies between these limits. The method used to calculate the confidence intervals is described in appendix 2.

<table>
<thead>
<tr>
<th>Ethnic Category</th>
<th>95% Confidence Intervals on Fraction of Leeds Adults Seen by ICS, 2013-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian British</td>
<td>0.0 2.3 4.5</td>
</tr>
<tr>
<td>Black British</td>
<td>0.0 2.8 4.9</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.0 3.6 5.9</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>0.0 4.0 6.0</td>
</tr>
<tr>
<td>White Other</td>
<td>0.0 2.2 4.2</td>
</tr>
<tr>
<td>White British</td>
<td>0.0 2.3 4.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Upper</th>
<th>Lower</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian British</td>
<td>2.5</td>
<td>2.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Black British</td>
<td>3.8</td>
<td>2.8</td>
<td>3.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>4.2</td>
<td>2.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Other Ethnic</td>
<td>4.0</td>
<td>2.34</td>
<td>3.2</td>
</tr>
<tr>
<td>White Other</td>
<td>2.22</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>White British</td>
<td>2.30</td>
<td>2.1</td>
<td>2.22</td>
</tr>
</tbody>
</table>
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Observations:

- 3.6 Adults who identified as mixed race per 1000 population per year were seen by an intensive community service one or more times during the period. We can be 95% confident that the population risk lies between 2.9 and 4.2.

- 2.2 Adults who identified as white British per 1000 population per year were seen by an intensive community service 1 or more times during the period. We can be 95% confident that the population risk lies between 2.1 and 2.3.

- Hence adults who identify as mixed race were 60% more likely to be seen by an intensive community service than the white British population. This difference is statistically significant at 95% confidence.

- A significantly higher fraction of adults in the following BME categories were seen by an intensive community service than adults in the White British population:
  - Black or Black British, 50% higher
  - Mixed, 60% higher
  - Other Ethnic Groups, 40% higher

Chart 11: The service user's ethnicity was recorded for 89% of the adults aged 16-64 seen by an intensive community service over this three-year period.

In chart 11, those service users with ethnicity ‘not stated’ are included as having a valid ethnicity recorded, as service users are free not to say their ethnicity. Patient records where the ethnicity was recorded as ‘no data’ or as ‘not known’ are shown as ‘missing’ on chart 11.

If the recording of ethnicity had been more complete, we might have found different patterns of service use.
6.3.4 Detentions under the Mental Health Act

When we presented findings to the LYPFT Equality and Inclusion Group, we were asked if we could do a similar analysis of those people who had been detained under the Mental Health Act.

Between April 2013 and March 2016, 1211 different adults aged 16-64 were detained under the Mental Health Act, under a service commissioned by the Leeds NHS Clinical Commissioning Groups, not including specialist services such as forensics. Of these, 750 identified as white British, 400 identified as BME, 10 preferred not to say their ethnicity, and ethnicity was missing for 51 people. Out of those people whose ethnicity was recorded, 35% identified as BME. These figures for total detentions include those who were sectioned on admission and those detained subsequently.

Service users are only counted once even if they were referred several times or were seen by more than one service. Only Leeds-commissioned adults who were admitted to an acute ward were included (specialist services are not included in these figures).

Chart 12 shows how many Leeds adults aged 16 to 64 were detained in an NHS mental health ward at least once per 1,000 population per year in Leeds by each ethnic category between April 2013 and March 2016, excluding specialist services.
Chart 13 shows the 95% confidence intervals on the fractions of the population of Leeds adults who were detained on a mental health ward at least once between April 2013 and March 2016. We can be 95% confident that the underlying level of risk lies between these limits. The method used to calculate the confidence intervals is described in appendix 2.

| 95% Confidence Intervals on fraction of Leeds adults detained 2013-16 |
|---|---|---|---|---|---|---|
| 3.0 | 2.5 | 2.0 | 1.5 | 1.0 | 0.5 | 0.0 |
| Upper | 1.4 | 2.5 | 2.2 | 2.1 | 1.2 | 0.66 |
| Lower | 1.0 | 1.7 | 1.3 | 0.9 | 0.69 | 0.6 |
| Risk | 1.2 | 2.1 | 1.8 | 1.5 | 0.9 | 0.61 |

Observations:
- A significantly higher fraction of adults in the following BME categories were detained under the Mental Health Act than adults in the White British population:
  - Asian or Asian British, 90% higher
  - Black or Black British, 240% higher
  - Mixed, 190% higher
  - Other Ethnic Groups, 140% higher

6.3.5 Dial House at Touchstone

During a recent 12-month period, roughly September 2015 to August 2016, 16% of all visitors to Dial House were from black and minority ethnic (BME) groups.

This is a substantial increase from 2012-13, the year before the Dial House @ Touchstone service was opened, where 3% of visitors to Dial House were from BME groups.

At the 2011 national census, 19% of the population of Leeds identified as black or another minority ethnic group.
7. Discussion

Population treatment rates are affected by:
- Levels of health need and by
- Barriers to accessing services.

Hence if the barriers to treatment faced by different ethnic communities are different, then a community which has greater needs may not receive higher rates of treatment (if it faces greater barriers).

Barriers include:
- Stigma around mental illness: stigma prevents people talking about mental health and prevents people from asking for help or accessing services;
- Awareness of what services are available and how they can help;
- Language and cultural barriers;
- Negative experiences of services in the past.

Language: Dial House @ Touchstone, a specialist BME crisis service, have realised by doing outreach in the local community that there is a stigma around mental health and found that just using the words “mental health” can be detrimental for somebody who would like to use their service. Dial House @ Touchstone took that on board and started to use ‘softer’ language than before, replacing words like “crisis” with “stress/feeling under the weather” or “mental health issues” with “not feeling yourself/changes in the way you feel”
Staff from minority groups: Leeds Survivor Led Crisis Service (LSLCS) feel that the most significant learning point for their service (which applies to their LGBT and Deaf projects as well as Dial House @ Touchstone) is that you can only make services truly accessible to people from minority groups by having them provided by people from those groups. Just under 50% of LSLCS staff are from BME groups because we needed to recruit so many BME staff to Dial House@Touchstone. This has made Dial House accessible too.

Other key learning for Leeds Survivor Led Crisis Service about how to make services accessible has been:

- The greater importance of religious and spiritual beliefs and needs in BME communities and

- The massive tendency to understate crisis – hence lower disclosure at DH@T around self injury, suicide attempts and being survivors of abuse. Our experience is that people from BME groups also understate at point of referral how bad things are – i.e. "I need to come to Dial House because my flat is cold" means “I’m desperately lonely and isolated to the point of feeling suicidal."

- Section 6.2 above refers to the issue of trust being harder to win. We also learnt that our printed promotional material was of limited value – word of mouth is much more important in trying to reach BME communities. This is why our referrals come from Solace (a service already trusted) and friends and family as opposed to statutory services, which is the case at Dial House (details shown in section 6.1 on page 3).

Risk factors for poor mental health include:

| Being a carer | Poor social support networks, incl. childhood neglect |
| Debt | Relationship / family problems |
| Discrimination including racism, and exclusion from family / community | Substance misuse |
| Homelessness | Transitions, life changes, including divorce, bereavement |
| Lack of positive role models | Trauma, incl. domestic violence |
| Long term health conditions, disability | Worklessness |

The pattern of use of crisis services in Leeds matched that found elsewhere in research studies and national data\(^1\,^2\,^3\), whereby people from BME communities are:

- More likely to use more intensive forms of crisis care such as hospital admission and intensive community services, while they are
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- No more likely, or less likely, to be assessed by a crisis service than white British communities. This study did not look at levels of access to less intensive services such as IAPT or GPs.

However we found that in Leeds, people who identify as mixed race were more likely to be assessed by a crisis service than those who identify as white British.

Some risk factors for poor mental health are higher in some BME communities than among large parts of the white British population:

- Unemployment (and hence also increased risk of debt)
- Lack of positive role models.

In addition, in refugee communities and some migrant communities, further risk factors are higher than in the white British population:

- Poor social support networks
- Trauma.

8. Conclusions

Third sector organisations as well as statutory services (such as GPs, A&E) are supporting people from black and minority ethnic communities to access help when they or someone they care for reach crisis point.

Dial House @ Touchstone, a new specific BME crisis service changed their service model and their use of language and recruited staff from minority groups. These changes, and other learning, resulted in a significant increase in the number of clients seen who were from BME communities, from 3% to 16% of all visitors to both Dial House services.

Between 2013 and 2016, the pattern of use of crisis services in Leeds has been:

- People from black, mixed, Asian and other ethnic communities were significantly more likely to be admitted to a mental health ward than people from white British communities.
- People from black, mixed and other ethnic communities were significantly more likely to receive intensive community services than people from white British communities.
- People who identified as mixed race were significantly more likely to receive a face-to-face crisis assessment with SPA / SPUR / ALPS than people from white British communities. Asian and Asian British communities were significantly less likely to receive a face-to-face crisis assessment with SPA / SPUR / ALPS than people from white British communities.
People from Black, Mixed, Asian and Other Ethnic communities were significantly more likely to be detained under the Mental Health Act than people from white British communities.

There were some gaps in ethnicity recording by services, especially in community services, where 1 in 5 service users in Leeds did not have their ethnicity recorded between April 2013 and March 2016.

Table 3: Summary of statistically significant differences in population treatment rates for crisis care in Leeds compared to the White British community

<table>
<thead>
<tr>
<th>NHS Crisis services</th>
<th>All face-to-face</th>
<th>Intensive Community Services</th>
<th>Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British 40,000 adults</td>
<td>17% lower than white British</td>
<td>50% higher than white British</td>
<td>Significantly higher than white British after standardising for age&amp;sex</td>
</tr>
<tr>
<td>Black or Black British 18,000 adults</td>
<td>50% higher than white British</td>
<td>150% higher than white British</td>
<td>Significantly higher than white British after standardising for age&amp;sex</td>
</tr>
<tr>
<td>Mixed 11,000 adults</td>
<td>60% higher than white British</td>
<td>60% higher than white British</td>
<td>140% higher than white British</td>
</tr>
<tr>
<td>Other Ethnic Groups 6,000 adults</td>
<td>40% higher than white British</td>
<td>100% higher than white British</td>
<td>Significantly higher than white British after standardising for age&amp;sex</td>
</tr>
<tr>
<td>White Other 22,000 adults</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A significantly higher fraction of people of mixed race backgrounds had used all three crisis services than the white British population.

The differences summarised in table 3 meant that overall:

- 19% service users seen face-to-face identified as black, Asian or other ethnic
- 22% service users seen by ICS identified as black, Asian or other ethnic
- 30% service users admitted to a MH ward identified as black, Asian, or other
- 35% service users detained under the mental health act identified as black, Asian or other ethnic group.
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Our findings were broadly similar to published research and national data.

We presented findings and recommendations to:
- LYPFT Equality & Inclusion group (14 Feb)
- Leeds North CCG (1 March)
- NHS Partnerships Mental Health Crisis & Urgent Care Meeting (10 March)
- LYPFT Mental Health Legislation Committee (4 May)

We presented recommendations about:
- Finding out more
- Exploring appetite.

We met with Dr Ghazala Mir from University of Leeds (24 April) to explore options for collaborative working.

9. Recommendations

Emerging next steps / recommendations:

1. Scope establishing a time-limited city-wide multi-agency group

2. Literature review of evidenced-based good practice

3. Hold a stakeholder event to identify actions: LYPFT-specific & city-wide actions which:
   - have clarity of purpose(s)
   - are action-oriented: co-produced- pilot and evaluate solutions
   - sustained action over several years
   - are sponsored/supported by Senior Champions.

Options for finding out more:

1. Audit of those presenting / being offered a service to identify factors in the differences observed.

2. Analyse the pathways through crisis treatment pathways by ethnic category:
   - Community Treatment Orders (CTOs) by ethnicity
   - % Of those already in treatment going into crisis by ethnicity
   - % Of service users disengaging from services by ethnicity
   - Length of stay by ethnicity
   - Length of engagement with community teams by ethnicity.

3. Identify further good practice on how to make services accessible. Leeds Survivor-Led Crisis Service have done some learning on this.

4. Ethnicity recording – continued action by Leeds Partnership NHS Foundation Trust to improve the completeness of ethnicity recording, especially by SPA and
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SPUR.

5. Further analysis of intake of crisis services:
   - Population (crisis) treatment rates for men and women separately
   - Population (crisis) treatment rates by age group
   - Population (crisis) treatment rates by narrower ethnic categories: for example break down the Asian / Asian British category into Indian, Pakistani / Bangladeshi; and similarly break down black / black British.
   - Distribution of high volume service users among ethnic categories
   - Volumes of ALPS referrals vs other referrals by ethnic category.
   - Analyse by deprivation using home postcode.

6. Would it help to gather any evidence from some communities? Any work would need a clear rationale and focus. There are two possible areas:
   - Firstly, recent service user stories and their experience of crisis and their pathways of support; and
   - Secondly, wider evidence from specific communities. It may help to gather evidence on experience of services by family members, carers, friends, and community members, and also people’s perception / knowledge / awareness of what support is available in Leeds when someone experiences a mental health crisis.

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11. References

1. Mental Health Crisis Care: commissioning excellence for Black and minority ethnic groups, Mind, March 2013

2. Mental Health Services for people from black and minority ethnic communities, Joint Commissioning Panel for Mental Health, July 2014


Appendix 1

Ethnicity Categories by the Office for National Statistics Used in the 2011 National Census

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>British, Irish, Gypsy or Irish Traveller, Any other White background</td>
</tr>
<tr>
<td>Mixed</td>
<td>White and Black Caribbean, White and Black African, White and Asian, Any other mixed background</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>Caribbean, African, Any other Black background</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>Arab, Any other</td>
</tr>
</tbody>
</table>

We used these categories in this report.

In this report, “White Other” includes:
- White Irish
- White Gypsy or Irish Traveller
- White Any other White background
Appendix 2

Tests of statistical significance used in this report

Tests of statistical significance enable us to tell the difference between:

1. Population groups where the underlying population risk is different;

2. Population groups where the underlying population risk is the same or similar but the total number people using a service over a (short) period is different as the period was not long enough for natural variations to even out.

We used data for a three-year period to make our statistical tests more sensitive to any underlying differences in population risk of using a mental health crisis service.

This appendix describes how JH calculated the confidence intervals displayed in:

- Chart 2, chart 5, chart 10, chart 13: Fraction of population who used a service
- Chart 6: Indirectly standardised admission ratio.

Chart 2, chart 5, chart 10, chart 13: Fraction of population who used a service

JH used the Binomial distribution. In this statistical model:

- $N$ = the number of adults living in Leeds in that ethnic group [We used the figure from the 2011 national census]
- $X$ = the number of adults living in Leeds in that ethnic group who used this service one or more times over the three-year period [Anonymised data extracted from LYPFT records]
- We calculated $P = X/N$ the fraction of adults living in Leeds in that ethnic group who used this service one or more times over the three-year period
- Note that the mean of the Binomial distribution $= N*P = X$
- We calculated the standard deviation of the Binomial distribution for each ethnic group separately as $= \sqrt{N*P*(1-P)}$
- We calculated the 95% confidence intervals for a two-tailed test as $1.96*standard deviation$. We calculated the confidence interval for each ethnic group separately as follows:
  - Upper confidence interval = mean + $(1.96*standard deviation)$
  - Lower confidence interval = mean - $(1.96*standard deviation)$
- While we did the statistical test of significance over the three year period, the charts display the average figures for a single year.
- Using the Binomial distribution assumes that the population risk of using a crisis service over the three-year period is the same for every individual adult in each ethnic group. JH believes that this statistical test is fit for this purpose. It gives similar results to the 'Rates' tool supplied by the Association of Public Health Observatories at reference 9, which JH would use in future.
Chart 6: Indirectly standardised admission ratio

JH used Byar’s method, as recommended in ‘Analytical Tools for Public Health’ [reference 9]. For 95% confidence intervals, Byar’s method is very accurate for observed values of 5 or more, which was the case here, where the lowest observed value was 27.

Again, we calculated two-tailed 95% confidence intervals for each ethnic group for each crisis service.