Race and mental health treatment

One year on, **Marcel Vige** assesses the adequacy of government responses to the Bennett Inquiry, in particular the government's five-year plan to tackle racial inequality across mental health services.

The death of David (Rocky) Bennett, a black man who was a detained patient in the Norvic Clinic, an NHS medium secure unit in Norwich, is a tragic illustration of how perceptions of race within mental health settings can influence interactions between staff and patients. There is now a wealth of evidence establishing the disproportionately high rates of diagnosis of schizophrenia amongst African-Caribbean people. African-Caribbean people are also more likely to receive coercive forms of care, spend longer in hospital and experience greater rates of transfer to higher security facilities (NIMHE, 2003).

Key Issues from the Bennett Inquiry

On the night of October 30th 1998, following a violent altercation between David and another patient, staff sought to separate the two men by moving David to another ward. When David was told that only he was to be moved, he reacted violently towards the staff. At this point David was physically restrained — this lasted for approximately 20 minutes. Between four and five nursing staff restrained him face down, sitting on his legs and across his upper torso. (There is still some contention about exactly how David was restrained.) Some time around 23:35 one of the staff members present noticed that David was not breathing. He was pronounced dead at 0020. On 17 May 2001 the inquest returned a verdict of 'accidental death contributed to by neglect' and said that the cause of death was due to restraint asphyxia and long-term anti-psychotic drug therapy (*www.inquest.org.uk*).

Considering broader questions raised by the evidence, the inquiry refers to a lack of assessment of and response to the ethnic and cultural needs of patients at the Norvic Clinic. Though there is no evidence of overtly racist behaviour from staff, there is evidence of racial abuse directed at Rocky Bennett by other patients. At the time, there was no firm practice of recording all such incidents. Evidence presented to the inquiry found that a particular staff member at the Norvic clinic did discuss aspects of ethnicity and culture with David Bennett. The clinic also provided a black newspaper to David, and halal food to Muslim patients. Despite this, the inquiry concluded that the Norvic Clinic lacked a consistent and appropriate response to the ethnic and cultural needs of David Bennett. The inquiry points out that health services must incorporate an awareness of and response to the personal history of black and minority ethnic patients. The importance of such a response is reflected in the following statement from the inquiry; "if a patient's cultural, social and religious needs are not scrupulously considered, these will inevitably affect his reactions and may exacerbate his symptoms. It is essential that every patient is treated according to his needs."

The inquiry points out that the decision to move David Bennett to another ward following the altercation was poorly handled. David had the impression that he was being moved because he was black. No attempt was made to explain that this was not the case. The general impression is that the importance of the racial dimension of the episode was not understood or appreciated by the staff in attendance. The inquiry makes the following comment "We conclude that the staff did not appreciate the need to speak to either patient in order to attempt to de-escalate the incident. They also did not appreciate the importance of doing this because they were unaware of the corrosive and cumulative effect of racist abuse upon a black patient. As it was, when the decision to remove David Bennett was taken, it was bound to have left him with the overwhelming feeling that he had been wrongly criticised and wrongly removed from Drayton Ward".

There was no coherent pattern or plan for the incorporation of ethnic or cultural needs into any package of care received by David, who had entered the mental health system in 1980. During this time, David was seen by numerous doctors and nurses in various parts of the country, yet the inquiry found no evidence that any of them suggested any alteration to meet his ethnic or cultural needs. The implication is that the pattern of treatment experienced by David Bennett is indicative of that of other patients from black and minority ethnic communities with similar mental health problems.

Though the inquiry found that asphyxia rather than medication was the cause of his death, David was being prescribed a multiple dose of anti-psychotics, the equivalent of one and a half times the maximum recommended dose. Apart from the obvious bad practice this represents, it lends weight to the widely held view that African-Caribbean people suffering from schizophrenia are receiving comparatively high doses of medication.

The control and restraint of David Bennett is arguably the most controversial aspect of the case. The inquiry points out that evidence on this issue is confused. There is however consensus on the period of time that David was subject to restraint — according to the inquiry, approximately twenty-five

minutes. The danger inherent in such restraint is reflected in the evidence given to the inquiry by Consultant Forensic Pathologist Dr. Cary; "Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when they are restrained for long periods. And that I think is a matter of fact. There is some debate however, as regards what sort of mechanisms may be involved in causing those deaths. But we do know that the deaths occur, firstly when people have been restrained in the prone position in particular. And just to clarify that, that means that they are face downwards, lying down. And secondly, that the deaths seem to occur when the restraint and the struggling against the restraint goes on for a long period and those, as I say, are two quite well established facts."

The Inquiry found that all staff involved in the incident had received training on the use of control and restraint techniques. Additionally, the behaviour of staff was in keeping with the policy of Norvic Clinic which did not place a time limit on such restraint. The case of David Bennett illustrates that the dangers outlined by Dr. Cary can arise despite staff being trained in control and restraint techniques. This is the principal reason why the inquiry recommended the imposition of a three-minute maximum time in which a person should be restrained in a prone position. To date, the government has refused to accept such a time limit.

The latest clinical guidance on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments (NICE, 2005) emphasises de-escalation techniques and monitoring of the patient's vital signs in all circumstances of intervention. The guidance material specifies that all those involved in the short-term management of disturbed/violent behaviour should be familiar with the requirements of the European Convention on Human Rights. However, the Joint Committee on Human Rights report *Deaths in Custody* states that "Reliance on prone restraint is a matter of concern for compliance with Article 2, given the known dangers of this position, evidenced by previous deaths."

The implication is that staff may be expected to engage in prone position restraint with full awareness that their behaviour may contravene Article 2 of the *European Convention on Human Rights*. Such contradictory messages are likely to generate inconsistent staff responses to conflict situations. Compounding these problems, evidence given to the Mental Health Act Commission (MHAC) reveals a lack of compliance with the Codes of Practice associated with the *Mental Health Act*. It seems then that current safeguards around the use of control and restraint are inadequate, both in terms of their scope and application.

Broader government responses

Prior to the publication of the Bennett Inquiry, the government had embarked on a comprehensive strategy to address racial inequality within the mental health system. After various stages of public consultation, the strategy was finalised in January 2005 with the publication of *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside services; and the Government's response to the independent inquiry into the death of David Bennett* (collectively referred to as DRE). In its previous incarnation, DRE spelled out the case for change by acknowledging the disproportionately negative experiences of BME people within the mental health system. Examples include higher rates of compulsory admission into hospital, higher rates of transfer to medium and high secure facilities, more severe and coercive treatments, less likelihood of having social care/psychological needs addressed within care planning/treatments processes. The relevance of these issues for the Bennett case explains the amalgamation of DRE and the official response to the Bennett Inquiry. The question for the DRE strategy is whether it will result in a shift towards a more equitable mental health system which responds appropriately to the needs of all patients, particularly those from BME communities.

As a statement of intention, DRE is certainly a positive step forward. The debate about the source of ethnic disparities within mental health has now shifted away from explanations located within notions of deviant lifestyles and genetic predisposition within black communities. The greater emphasis on socio-cultural explanations is in line with the concept of 'institutional racism' defined by McPherson (1999) as: "The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."

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Despite the fact that the government has rejected the Bennett inquiry recommendation for ministerial acknowledgement of institutional racism within the mental health system, DRE is intended to address the issues referred to in McPherson's definition. How adequate DRE is in meeting this challenge depends on the extent to which it is informed by a shift in understanding by government of the depth and scope of change at both the conceptual and structural level within the mental health system. The government's refusal to accept key recommendations from the inquiry suggests that such a shift in thinking has yet to happen.

'Community engagement' is the central plank of DRE. This is to be delivered through two key elements — 80 community development projects funded by NIMHE and 500 Community Development Workers (CDWs) funded by Primary Care Trusts (PCTs). Both initiatives are intended to compliment the Race Equality Schemes that PCTs must have to meet their statutory requirements under the Race Relations (Amendment) Act. According to DRE, community development projects are expected to: "help to build capacity in the non-statutory sector,

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develop partnerships between the nonstatutory and statutory sectors, and offer new and innovative services that meet needs. They will aim to improve pathways to care and recovery, mental health awareness and satisfaction with care."

Ultimately such initiatives must translate into meaningful changes in the configuration and operation of mental health services. Whilst DRE effectively pinpoints necessary adjustments which, if implemented, would bring about change across the entire spectrum of ethnic inequality, there remains a heavy reliance on the 'good will' of statutory agencies to carry changes through in a meaningful way. Unfortunately history shows that any strategy that relies on such 'good will' is doomed to failure.

The intention of DRE is its greatest strength — the lack of definitive targets is its greatest weakness. Despite falling short of acknowledging institutional racism, the strategy certainly goes further than any before it in officially recognising the extent that care delivered to black people by mental health services is disproportionately inadequate, counterproductive, even life-threatening. However, DRE does not have the wherewithal to refashion the epistemology and assumptions that form the core of professional knowledge within the mental health system. DRE does not authoritatively mandate services to reconfigure themselves according to new paradigms and values informed by diverse cultural perspectives. Without addressing the issue of racial inequality at such fundamental levels, DRE falls short of its own rhetoric. Ominously absent from the strategy is any coherent understanding of or response to the causal factors that perpetuate ethnic inequality within the mental health system. These factors relate to the cultural history of the mental health system and the influence this still has on the recruitment, training and retention of staff at all levels. Also relevant are the theoretical models that underpin notions of mental illness and wellness, and the politicised climate that influences the development of mental health policy.

Despite the long history of woefully poor treatment of black people within statutory mental health services, the inquiry into the death of David Bennett and DRE seem to indicate a readiness by government and policy makers to seriously confront such issues. As indicated by the deficiencies in DRE outlined above, these initial steps are still tentative. There is still a reticence to fully grasp the realities of institutional racism and to refashion established notions and received wisdom within the mental health professions which lead to inappropriate assumptions and evaluations of BME people as dangerous, psychotic and in need of containment. The long history of campaigning on these issues has led to the present position where there is now official acceptance of such inequality. The real goal is for culturally appropriate, racially unbiased services to emerge from of the commissioning, development, funding and inspection arrangements that bind policy makers with service providers. Only then will the lessons from the inquiry into the death of David Bennett have been learned and the spirit of DRE properly fulfilled.

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