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Police Admissions to a Psychiatric Hospital
Demographic and Clinical Differences Between Ethnic Groups

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Between October 1983 and December 1985, 268 patients were brought by police to a psychiatric hospital in south London under section 136 of the Mental Health Act 1983. Comparisons were made between 'blacks' and 'whites' on several clinical and demographic variables. The vast majority of admissions received a psychiatric diagnosis. An excess of black admissions was recorded. Black men were younger, were more likely than whites to be given neuroleptics, to be put on compulsory orders, and to be given an out-patient appointment when discharged from hospital. More black men were given a case-note diagnosis of schizophrenia or drug-induced psychosis. The differences in clinical management between ethnic groups could be at least partly accounted for by these differences in diagnosis. Treatment did not appear to be independent of diagnosis among the black admissions.

High rates of mental disorder among Afro-Caribbeans in Britain have been reported (Rwegellera, 1977; Cochrane, 1977; Dean *et al*, 1981; Littlewood & Lipsedge, 1981; McGovern & Cope, 1987*a*; Harrison *et al*, 1988). The best of these studies (Harrison *et al*, 1988), using a prospective design and standardised diagnostic criteria, found a rate of schizophrenia among young Afro-Caribbeans 14 times that of the similar age group in the general population. These findings have provoked investigators and commentators to speculate on the possible reasons for these increased rates, but most theories are lacking in research evidence. Among those theories currently most in favour with investigators (McGovern & Cope, 1987*a*; Littlewood & Lipsedge, 1988) are the possible effects of environmental stress, including racism and alienation, especially among young and British-born blacks, or a cohort effect, where mental illness is presenting at a younger age in a vulnerable subgroup. The importance of the genetic contribution to the increased rates is as yet undetermined.

The number of unusual diagnostic categories, especially drug-induced psychoses, has also raised the possibility that misdiagnosis, or racism in psychiatry (Black Health Workers and Patients Group, 1983), may contribute to the high rates of diagnosis of mental illness in Afro-Caribbeans, but this explanation is at variance with the results of at least one carefully designed study (Harrison *et al*, 1988) employing a range of standardised diagnostic criteria.

An excess of compulsory and police-referred psychiatric admissions from the Afro-Caribbean population has also been reported (McGovern & Cope, 1987*b*; Ineichen *et al*, 1984; Rwegellera, 1980; Rogers & Faulkner, 1987; Dunn & Fahy, 1987). A higher rate of schizophrenia has been recorded among compulsorily and non-compulsorily detailed Afro-Caribbean patients than among whites (McGovern & Cope, 1987*b*; Harrison *et al*, 1988). Police admissions to psychiatric hospitals have been a focus of attention for those who advocate a social control hypothesis in relation to psychiatry (Miller & Rose, 1986). The possibility that high rates of police admissions may be partly affected by conscious or unconscious racist attitudes has also been a cause for concern among some psychiatrists. Writing about his clinical experience in the East End of London, Littlewood (1986) states that "it is certainly true" that police can be overtly racist and selectively pick out mentally healthy black people, and take them to psychiatric hospitals under section 136 as an alternative to arrest. This observation may come as a surprise to some workers, since the referral procedure is viewed by police officers as cumbersome, time consuming, and frustrating (Dunn & Fahy, 1987). Nevertheless, it is possible that misidentification of mental disorder in Afro-Caribbeans by the police may lead to inappropriate referrals for psychiatric evaluation.

This study aimed to compare black and white emergency police referrals to an urban psychiatric hospital based in a catchment area with a large Afro-Caribbean population. We attempted to establish whether rates of referral of blacks were different from those for whites, to ascertain the ability of police to identify mental disorder among different ethnic groups, and to examine the reasons for referral and the outcome of admission among the ethnic groups. As some evidence from the UK and the USA suggests that the route of admission to hospital

among blacks may differ from that of whites because of the severity of the psychiatric disturbance at the time of referral (Schleifer *et al*, 1968; Rwegellera, 1980), we also aimed to establish whether there were any differences between blacks and whites in the reasons for police intervention.

Method

This study was undertaken at a large London mental hospital, situated within its inner-city catchment area. It serves the western half of one of London's poorer boroughs, as indicated by high levels of poverty, unemployment, homelessness and one of the largest proportions of single-parent families in the UK (Lambeth Directorate of Town and Economic Planning, 1981). According to the 1981 census (Office of Population Statistics and Surveys, 1981), which estimated the ethnic populations according to the birthplace of the head of the household, while recording place of birth for each individual, the population from the New Commonwealth and Pakistani (NCWP) accounts for 23% of the total population of the borough, the Afro-Caribbean population for 14%, East Africans for 1%, and others 3% (Table I). Approximately 15% of the borough population was born in the NCWP.

In this borough people thought by the police to be mentally disordered and in need of immediate care or control are taken to a police station, and after negotiation by telephone with a psychiatrist are transferred compulsorily, under section 136 of the Mental Health Act 1983, to hospital for assessment. Although section 136 is strictly speaking not an admission order, in practice it was used as such in this hospital at the time of the study. Patients were assessed and admitted by the duty psychiatrist, and were also assessed by a social worker after admission to the ward.

The Mental Health Act 1983 was implemented in October of that year. Data were collected retrospectively from the case notes of consecutive section-136 referrals from October 1983 to December 1985. All section-136 referrals to the hospital under study are recorded in a file by the admissions officer or, after hours and at weekends, by the duty nursing officer. A strict catchment area system was operated at the hospital, so that only patients living inside the area, and those of no fixed abode who were picked up inside the area were assessed at the hospital. During the period of study there were 268 such referrals.

A proforma was designed to collect the following data from the case notes:

(a) demographic data, including age, sex and ethnic status (recorded firstly by country of birth as documented in the case notes and secondly by skin colour as recorded in the medical notes and the nursing patient profile, a document completed by the admitting nurse)
(b) events leading to detention by the police, as documented on the police referral form
(c) psychiatric history, as revealed by previous psychiatric admissions and previous section-136 admissions
(d) treatment, including the use of psychotropic medications, the duration of admission, and the implementation of further compulsory orders
(e) case-note diagnosis on discharge (schizophrenia, including paranoid syndromes and schizoaffective disorder, hypomania, depression, situational crisis, alcohol and drug misuse, personality disorder, drug-induced psychosis, no diagnosis, and other diagnoses)
(f) follow-up, transfers to other hospitals and offers of out-patient appointments.

Statistical analyses were performed using the χ^2 test with Yates' correction and the *t*-test.

Results

There were 165 white patients (61%), and 88 (33%) black (50 of whom were born in the West Indies, 7 in Africa and 31 in Britain). Seven patients of South Asian origin (3%) were excluded from the study, and eight sets of case notes (3%) were not available, and these cases were not analysed further. Fifteen per cent of the borough's population were immigrants born in the NCWP, but 22% of the section-136 patients were born in these countries. There was an excess of male admissions in both groups (Table II).

In the borough 29.3% of Afro-Caribbeans and 25.6% of white UK residents were aged 16–29 years. Afro-Caribbean

TABLE I
Persons by birthplace of household head for Lambeth, inner London, and Greater London, 1981

	Lambeth		*Inner London*		*Greater London*	
	no.	*%*	*no.*	*%*	*no.*	*%*
UK and Eire	165 055	69	1 691 500	72	5 138 525	80
Caribbean	32 395	14	198 752	8	306 792	5
East Africa	2 528	1	22 302	1	90 690	1
Total NCWP[1]	56 071	23	457 071	19	945 148	15
Rest of world	17 728	7	210 748	9	408 969	6
Total population	238 854	100	2 359 319	100	6 492 642	100

1. New Commonwealth and Pakistan.

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TABLE II
Demographic details of patients on section 136

	Men		*Women*	
	Black	*White*	*Black*	*White*
Numbers	52	105	36	60
Age range: years	19–46	18–85	19–59	19–64
Mean age: years	27*	35*	32	36
Standard deviation	5.9	12.6	11.1	13.0
Previous psychiatric admissions[1]	34 (67%)**	76 (73%)**	33 (92%)***	52 (87%)***

1. Data missing on two patients.
*Two-sample *t*-test showed a significant difference between the mean ages of black men versus white men, $P<0.001$ (differences between means = 8.8, 95% confidence interval = 11.7–5.8, degrees of freedom = 150). Difference between mean ages of black men and black women is also significant (difference = 5.5, 95% confidence interval = 9.6–1.4, degrees of freedom = 49, $P<0.01$).
**Black men v. white men, $\chi^2=0.66$, d.f. = 1, $0.5>P>0.25$.
***Black women v. white women, $\chi^2=0.76$, d.f. = 1, $0.5>P>0.25$.

men in this study were significantly younger than both white men and black women.

The majority of patients had a previous psychiatric history (Table II); 73% of white men and 67% of black men had a history of psychiatric admission, in comparison with 92% of black women and 87% of white women. For those men with a previous admission, the average number of admissions was 3.0 for whites and 3.3 for blacks. The proportions admitted on section 136 previously were 24% for black men, 40% for white men, 32% for black women, and 24% for white women.

The written reasons given by the referring police officer were recorded on police form 434. The commonest reasons were threats of or actual self-harm, threat of or actual violence, wandering, public nudity, bizarre behaviour, and incoherence. These types of behaviour were reclassified into three categories: suicidal, violent, and non-violent behaviour. Suicidal behaviour was more common among white patients. Violent presentations were more common among white women and black men, but because of the absence of any reports of suicidal behaviour among the latter group, non-violent behaviour was also more common among black men than white men.

Schizophrenia was the commonest diagnosis in all groups, but was made twice as often in blacks as whites. Personality disorders and alcohol and drug misuse were more commonly diagnosed in white patients and drug-induced psychosis was more frequently diagnosed in black men (Table IV).

TABLE III
Types of behaviour leading to section-136 admission

	Suicidal behaviour		*Violent behaviour*		*Non-violent behaviour*	
	no.	*%*	*no.*	*%*	*no.*	*%*
Black men	0	0	30	58	22	42
White men	14	14	50	49	38	37
Black women	1	3	10	31	21	66
White women	9	15	24	40	27	45

Data not available on seven patients.

Because of the age difference between blacks and whites, a comparison was made between black men and white men under the age of 30 years. When this was done the proportion of blacks in each diagnostic category remained virtually identical, but among white men the proportion receiving the diagnosis of personality disorder and drug-induced psychosis increased from 11% to 19% and from 7% to 15% respectively. The proportion receiving a diagnosis of hypomania and alcohol misuse decreased from 18% to 10% and from 20% to 8% respectively.

Black men were more likely than white men to receive psychotropic medications, especially neuroleptics (Table V). Black men were also more likely to become involuntary patients after the section-136 order lapsed (72 hours).

Black men were more likely to be offered follow-up than white men (48% v. 25%, $P<0.025$). Out-patient follow-up was offered to 71% of black women, versus 58% of white women ($P>0.01$).

If the diagnostic groups of schizophrenia, hypomania, and drug-induced psychosis are combined into one 'psychotic' category, then although small differences remain between the proportion of black or white men prescribed neuroleptics (41 (91%) v. 42 (86%), Fisher's exact test, $P=0.1658$), placed on further compulsory orders (21 (47%) v. 20 (41%), $\chi^2=0.38$, d.f. = 1, $0.75>P>0.5$), and offered further out-patient follow-up (25 (56%) v. 18 (37%) respectively, $\chi^2=2.36$, d.f. = 1, $0.25>P>0.1$), these differences are no longer statistically significant.

Discussion

Estimates of the total size of the individual ethnic subgroups are subject to sampling errors, which have been detailed by Harrison *et al* (1988). The 1981 census did not include a question on ethnic origin, but households are grouped according to the country of origin of the head of household, thereby failing to take account of the British-born children of immigrants who have moved to independent accommodation. A discussion paper from the Office of Population Censuses and Surveys (1982*a*), using

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TABLE IV
Case-note diagnosis

Diagnosis	*Black men*		*White men*		*Black women*		*White women*	
	no.	*%*	*no.*	*%*	*no.*	*%*	*no.*	*%*
Schizophrenia	23	44	22	21	18	50	15	25
Hypomania	9	17	19	18	12	33	14	23
Depression	0		3	3	2	6	6	10
Situational crisis	1	2	6	6	3	8	3	5
Alcohol/drug misuse	0		21	20	1	3	1	2
Personality disorder	0		12	11	0		10	17
Drug-induced psychosis	13	25	7	7	0		4	7
No diagnosis	5	10	5	5	0		5	8
Other	1	2	10	9	0		2	3

TABLE V
Clinical management of admissions

	Neuroleptics given		*Kept in for over 72 hours*	
	no.	*%*	*no.*	*%*
Black men	46	90*	46	88**
White men	66	63*	76	74**
Black women	30	83	29	81
White women	48	80	44	73

*Black men v. white men, $\chi^2 = 12.3$, d.f. = 1, $P < 0.001$.
**Black men v. white men, $\chi^2 = 4.5$, d.f. = 1, $0.05 > P < 0.025$.
Medication: black women v. white women, $\chi^2 = 0.25$, d.f. = 1, $0.75 > P > 0.05$ (NS). (Data on two patients not available.)
Length of admission: black women v. white women, $\chi^2 = 0.7$, d.f. = 1, $0.5 > P > 0.25$ (NS).

the results of the Labour Force Survey (LFS) (1982*b*), which included a question about ethnic origin, estimates, that using a head-of-household definition, 90% of the NCWP population will be included. However, 19% of the inhabitants of such households may not be of NCWP ethnic origin. Taking these correction factors into account, the LFS estimate of the population of NCWP origin in England and Wales gives a result which is very similar to that of the 1981 census. Although Landau (1986) has suggested a 0.9 'correction factor' be applied to the head-of-household estimate, we follow the example of Harrison *et al* (1988) in ignoring this factor in order that local variations in the proportion of 'mixed marriages' and poor response rates to the LFS should not lead to an under-representation of the Afro-Caribbean population. Using these figures, the Afro-Caribbean and African population accounted for 15% of the hospital's catchment-area population, but 33% of section-136 admissions were black (West Indian, African, or British born).

The results obtained for diagnosis of section-136 admissions in this study are consistent with those of Rogers & Faulkner (1987), who reported that more than 90% of black and white police referrals were judged by the examining psychiatrist to suffer from a psychiatric disorder. Under the Mental Health Act 1959, Kelleher & Copeland (1972) showed that police- and doctor-initiated compulsory psychiatric admissions had similarly high rates of mental illness diagnosed during admission. Fahy *et al* (1987), comparing rural and urban police admissions with urban compulsory admissions initiated by doctors (section 4), found that more than 85% of each group received a psychiatric diagnosis on admission. In the current study, clinicians judged more than 90% of black and white admissions to be suffering from a mental illness. These results, taken in conjunction with the reasons given by the police for referral, tend to confirm the appropriateness of the referrals. What remains a problem is the different pattern of diagnoses between whites and blacks, especially the relative frequency of diagnosis of drug-induced psychosis among black men. To determine whether this diagnosis represents a genuinely high rate of drug-induced toxic states, a reluctance to diagnose schizophrenia, or misidentification of other short-lived psychotic or non-psychotic states remains to be tested in a prospective trial with standardised diagnostic criteria used by raters who are independent of the attending clinicians.

The referral of psychiatric patients to hospital can be cumbersome and time consuming for the police officer (Dunn & Fahy, 1987). American research confirms that police are reluctant to intervene directly in cases where mental illness is suspected. Bittner (1968) found that the usual reluctance to intervene where there is an allegation or an appearance of mental illness was usually waived in situations where attempted suicide or non-trivial violence was a factor, as well as situations where grossly abnormal affect, thought disorder or bizarre appearance were present. The police are also more likely to intervene if the patient's doctor or teacher is involved. It has also

been clearly demonstrated in a field study by Teplin (1983) in the USA that police officers tend to under-identify mental disorder rather than overidentify it, as the social control hypothesis would imply. The work of Schleifer *et al* (1968) demonstrated that police did not refer black prisoners for psychiatric evaluation until they were more disturbed than their white counterparts. These studies have not been replicated in Britain, but it would be surprising if the results were very different. Our study suggests that overidentification of mental illness by the police is not a major problem in the catchment area of the hospital studied. Nevertheless, we do not know how many mentally ill people are being inappropriately referred to the courts or are being dealt with without resorting to prosecution or psychiatric referral.

Following admission to hospital it is apparent from this study that black patients are more likely than whites to receive psychotropic medications, to be kept in hospital longer, and to be placed on a further compulsory order. However, it appears that an increased rate of psychosis accounts for these differences, which supports the findings of McGovern & Cope (1987*b*) and challenges the findings of Littlewood & Lipsedge (1981), who suggest that treatment is independent of diagnosis in this group.

Most police referrals are young, socially disadvantaged (74% of blacks and 78% of white men were unemployed), and have a previous psychiatric history. What is so far unclear is how these social factors may influence the route of referral and the time taken before presentation to services in Britain. The reports in the literature that suggest that young black men present with a more disturbed or violent picture (Hitch & Clegg, 1980; Rwegellera, 1980; Harrison *et al*, 1984), which may in turn lead to police involvement, are not supported by the results of this study.

We would suggest that future studies should focus on earlier decision-making processes that lead eventually to police referral to hospital or criminal prosecution. In particular it is of interest to assess how the social context in which a patient of any ethnic group finds himself facilitates non-compulsory referral, and how these factors influence the police in their decision making. We suspect that ethnic group is likely to become a more important issue where the policeman's lack of expertise in diagnosing mental disorder is compounded by the additional difficulty of dealing with subjects from another ethnic group. In our view this combination of problems is more likely to lead to disposal through the criminal justice system rather than through the psychiatric services. Studies of rates of mental illness among remand and convicted prisoners of differing ethnic groups and, ideally, field studies of police–client interactions will begin to address some of these issues.

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