detention; that is, the likelihood of ethnic bias in clinical assessment (severity of condition or establishing *nature* and *degree*) and attribution of risk, a process that is less than perfect in the ordinary clinical settings, and especially so during crisis assessments.

Simply examining the outcomes of assessments by AMHPs or medical practitioners, responsible for detention under the Act, is no more likely to reveal such subtle variations in clinical decision-making than studying cohorts of detained patients. This perhaps explains why two previous meta-analyses, one by Singh and funded by the Department of Health, also confirmed ethnic variations in detentions. The findings of the current study by Singh *et al*. are also inconsistent with annual reports from the Care Quality Commission (and its predecessor organizations) on admissions and detentions in hospital.

It would be helpful if future studies like this are able to focus on particular ethnic groups who are most at risk of detention under the MHA. In this study, for example, the ethnic groups who are most likely to be detained are Black and 'Other' ethnic groups, the latter including people of mixed race. Asians have the lowest risk of detention following AMHP assessment. What is required is analysis of data by specific ethnic groups (compared to white groups) to establish how the MHA operates in relation to those ethnic groups who are at highest risk of detention. It is also imperative to include 'upstream' processes' if explanations for variations in clinical decision making are sought.

The data in Table 4 in the paper raise the possibility of a site × ethnicity interaction, i.e. the relationship between detention and ethnicity is different in different sites. This is a major weakness of the study. AMHPs (ASWs) in London appear to have a much lower threshold for detentions (for all ethnic groups) compared to Oxford and Birmingham. This might be explained by poorer access to alternatives or more co-morbid conditions and other risk factors, such as substance misuse, homelessness, higher population density and higher rates of schizophrenia in London. This site × ethnicity interaction – reflecting considerable heterogeneity – in this study makes any generalization about sites or ethnicity highly problematical. Interaction between site and ethnicity means that the relationships with ethnicity are different for different sites. The authors attribute the significant regional variation in detention to differences in service provision between London and the other two sites. However, there is insufficient evidence to support such an assertion; differences in clinical practice might equally account for such regional variation. Ethnic differences in detention rates are likely to be susceptible to variations in clinical thresholds.

Finally, any invocation to 'move on from considering racism' in our public institutions must be treated with extreme scepticism. Such a suggestion is particularly alarming when psychiatrists try to rehabilitate their practice and justify the procedures and processes of mental health care in the face of significant evidence of enduring ethnic inequalities in service experience and outcome. The culture of care within the health service is being closely scrutinized as a cause for concern, so bland reassurances about systems of care, which are not based on hard evidence, are likely to be interpreted as further signs of professional complacency and lack of political will.

What we need is a clear commitment and investment (including research) to understand why people from black and minority ethnic groups continue to be disadvantaged in most aspects of psychiatric care in the UK so that we can seek appropriate and effective solutions to these problems. These concerns are shared by many other patient and public bodies. What is required is a proper scrutiny of such concerns along with comparative analysis of upstream factors.

Declaration of Interest

None.

Reference

Singh SP, Burns T, Tyrer P, Islam Z, Parsons H, Crawford MJ (2013). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*. Published online: 24 June 2013. doi:10.1017/S003329171300086X.

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Letter to the Editor

'Ethnicity as a predictor of detention under the Mental Health Act': a response to Singh *et al.* – a reply

We thank Dr Sashidharan and colleagues (Sashidharan *et al*. 2013) for their interest in our paper (Singh *et al*. 2013). They state several well-rehearsed opinions and

also raise important questions about facts and science. The latter include: (*a*) that the study was not blind and practitioners were aware of the purpose of the study; (*b*) that denominator should have been different since ethnic bias might be operating prior to the decision to assess someone under the Mental Health Act (MHA); (*c*) that since ethnic bias might operate in risk assessment, risk variable should not be included in the regression model; (*d*) ethnicity–site interaction is a major weakness in our study; and (*e*) upstream factors should be better explored in future research. We will restrict our response to these questions.

The AMEND study specifically set out to assess the impact of two changes made to the MHA (2007 amendment to the 1983 Act) – the single definition of mental disorder and inclusion of the Appropriate Treatment Test. Prospective data were collected over 4 years. Practitioners were contacted at the start of the study to explain its purpose and were not told that we were exploring ethnic bias in clinical practice. We therefore do not accept the claim that explaining the study once would change practitioners' behaviour over the next 4 years.

We used the assessed population as a denominator since we wanted to explore why some assessed patients get detained and others (almost a third in our study) do not. We found that individuals with serious mental disorders who were at risk and had poorer social support were most likely to be detained. Our findings could be interpreted simply as this: populations at higher risk of serious mental illness will also have higher rates of detention. This is unsurprising. Consequences of an illness are more frequent in groups with higher rates of that illness, analogous to the well known finding that resistant hypertension is more common in ethnic minority groups who are also at greater risk of its cardiovascular complications (Sarafidis *et al*. 2013).

We agree that we cannot rule out ethnic bias in who gets assessed or in the assessment of risk, but we cannot claim that such bias therefore exists. A basic tenet of science is that the burden of proving a hypothesis rests on those who state the hypothesis. To make an assertion and then demand that others find evidence to refute it is not science but ideological positioning. Interestingly, in our study we found no evidence of ethnic differences in clinicians' assessment of the presence of risk. To address the point about modelling risk in the analysis, we have re-analysed the data using the logistic regression methods described in the paper, but without entering the risk variable as a possible predictor variable. The results show that ethnicity, even when forced to remain in the model, still has a non-significant effect on the odds of detention ($p=0.582$) and the odds ratios for other predictor variables remain similar.

Ours is the largest, but by no means the only study to have found that controlling for confounders eliminates or significantly diminishes the effect of ethnicity on detention; others have reported the same (Cole *et al*. 1995; Lawlor *et al*. 2012). Previous studies, including meta-analyses (Bhui *et al*. 2003; Singh *et al*. 2007) suffer from precisely the weaknesses that concern Sashidharan *et al*. – differing denominator populations, lumping of diverse ethnic groups into single categories, failure to account for controlling factors, etc. We believe that our study deals with many of these inadequacies in a large and robust dataset.

We have no evidence to suggest that our site differences show ethnic bias operating in psychiatric practice in London and not in Birmingham and Oxford. We agree that site–ethnicity interaction may well be explained by variables suggested by Sashidharan *et al*.: poorer access to alternatives, more co-morbid conditions, substance misuse, homelessness, etc. These are all inadequacies in service provision to meet the needs of the local population. There may well be differences in clinical practice across sites and different clinical thresholds for assessment and detention, dependent upon resource availability.

We have no intention to 'rehabilitate' psychiatry, as stated by Sashidharan *et al*. British psychiatry has a strong tradition of attempting to understand ethnic differences in mental health care, challenge psychiatric practice where needed, and alter service provision to meet the needs of ethnic minorities. We agree that we must do more to understand upstream factors and reduce ethnic difference in mental health care. We quite understand that when powerful opinions on an alleged fact are promulgated by any individual or group, it is not easy to alter these through argument alone. But when the level of evidence improves to the point at which the facts tend to support an alternative explanation, at some point the opinions have to change. We do not presume that the results of the AMEND study are sufficient to effect this change, but they speak quietly for themselves and lessen the need for dogma in this particular debate.

Declaration of Interest

None.

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