Author’s response to reviews

Title: Ethnic inequalities and pathways to care in psychosis in England: A systematic review and meta-analysis

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A formatted authors' response letter has been included as a supplementary file

Reviewer #1: Peer reviews of systematic reviews can be an onerous task, but it was a pleasure to read this thorough, well-conducted and clearly described review. Your review largely provides an update on existing reviews, including new relevant data published on findings in England over the last 6 years. This review is timely given current consideration by the UK Government to review the Mental Health Act, and given the need to meaningfully tackle these inequalities. Your review strengthens the evidence base here, and should become the reference work in the field.

I have some suggestions to improve the manuscript:

We would like to thank the reviewer for these positive comments.

1. Abstract: I think you should include results which show that the South Asian group is also more likely to be compulsorily admitted. The abstract is perhaps overly-focussed on black groups, and more balance should be given here.

We agree that balance is important in the abstract. We had already included results for the South Asian group, including significantly higher rates of civil detentions for South Asian relative to White patients (OR 1.50, 95% CI 1.07 to 2.12, n=10). We had also included evidence on higher repeat admissions for the South Asian group, and now have additionally inserted the p-value for subgroup differences to illustrate the significance of this result.
2. Abstract: The conclusion that your review reveals persisting but not worsening patterns needs evidencing. From reading the paper you did not explicitly seek to test whether these inequalities changed over time (for example, via meta-regression).

Thank you for pointing this out. It is correct that we did not explicitly test whether inequalities changed over time, but these were important observations to note; we have now conducted additional subgroup analyses across all outcomes and main ethnic groups by decade of publication (1980-1989; 1990-1999; 2000-2009; 2010-2017). These analyses show no significant subgroup differences over time. We have added these findings to the abstract, results of all outcomes and the discussion. We have also described our approach to doing this in the Meta-analysis section of the Methods part of the paper (last paragraph of this section, page 8, line 3).

3. Methods: p4. "We then carried forward [studies] rated as medium or high". This initially made sense, but of your 40 included studies in Table 2, eight were rated as low quality and included. This seems to diverge from your methodological approach, and should be rectified. Seven out of eight of these studies were published before 2012.

By saying that we carried forward primary studies included in systematic reviews or meta-analyses of medium or high quality, we refer to the quality of the systematic reviews or meta-analyses that we examined. So, 29 primary studies were identified in the reference lists of previous medium or high quality reviews or meta-analyses, while 11 studies were identified from the additional search for primary studies between 2012 and 2017. As such, this produced a total of 40 studies included in our updated meta-analyses. This information had already been included in Figure 1 and the beginning of the results section (page 8).

However, in order to clarify our approach, we have altered the sentence quoted to: “We then considered the references in those systematic reviews and meta-analyses that we scored as being of medium or high quality (see AMSTAR quality assessment below), to identify relevant primary studies to carry forward. This was supplemented by an additional search (conducted on 18.10.17) for more recent primary studies published between 2012 and 2017 (as the latest meta-analyses considered research only up to 2012 [6, 17]). We restricted our searches to four databases: MEDLINE, Embase, PsycINFO, and CINAHL. We examined both primary studies carried forward from previous medium and high quality systematic reviews and meta-analyses and and those published more recently into the combined updated overall meta-analyses” (Search strategy and screening section, paragraph 3, page 4-5).
4. Methods: p5. "Language and region" section. For the avoidance of doubt please confirm or otherwise clarify whether all studies included in this review had to be conducted in England or Wales (consistent with the scope of the MHA.

Thank you for pointing this out. It is correct that studies had to be conducted in England or Wales to be included (consistent with previous pathways reviews and as key legislation such as the Mental Health Act 1983 only applies to people residing in these countries). We have therefore clarified this inclusion criterion in the ‘Language and region’ section (page 5).

We have also indicated that although Wales was covered in our search and inclusion criteria, all the studies included for our meta-analyses were conducted in England as no studies were found that included Wales (in the ‘Language and region’ section and the Abstract). As a consequence, references throughout the manuscript have been changed from ‘the UK’ to ‘England and/or Wales’ when we refer to our inclusion criteria and to ‘England’ only when we refer to our actual included studies. In order not to give the false imprecision that our meta-analyses also cover ethnic inequalities in pathways to care in Wales, we have also only referred to ‘England’ in our title.

5. Methods: p7: "Subgroup analyses for compulsory admission were conducted by patient type, first episode psychosis compared to recurrent admissions and specific sections of the Mental Health Act". This may not be clear for the unfamiliar, non-specialist reader. I would define what you mean by FEP vs recurrent admissions. More importantly, many readers (especially outside the UK) will not be familiar with the various "Sections" of the MHA. The majority of your paper focuses on differences in Section 2, but this section (or others) is not defined anywhere. I suggest adding a Supplementary Table of the Sections and their definitions.

We have changed the wording to make it clearer that we refer to first vs. repeat admission: “subgroup analyses of … first compulsory admission (either for those experiencing a psychotic episode for the first time or without reference to the patients’ illness stage) compared to those previously admitted who are then readmitted (compulsory) one or more times” (last paragraph of the Meta-analysis section, page 8, line 1). For clarity, and as this relates to admission frequency rather than the episode of their psychosis, we have also changed any other references elsewhere in the manuscript from ‘episode’ to ‘admission’.

We have attached an Additional file 5 with the resubmission that lists all of the sections of the Mental Health Act that are referred to in the papers we include and we have defined each of these sections. Including these in the paper would lengthen it. We explain in the paper that Section 2 is for assessment over 28 days (Compulsory admission section in the Results, paragraph 2, line 3, page 9).
We have also changed the wording from civil/forensic populations to civil/forensic detentions throughout the main manuscript to make this clearer.

6. Results: please report any "p=0.00" as "p<0.01", since p will very rarely equal zero.

We have changed all "p=0.00" to "p<0.01" in the manuscript.

7. Results: p9: "Analyses of psychosis episode indicate a significantly (p=0.07)". While I acknowledge that you set a liberal p-value of 0.10 for inclusion of results, this still points to only weak evidence of a difference between repeat compulsory and first admission only differences for the black vs white groups, as indicated by the overlapping 95% CIs presented in your results

Thank you for this observation. We have emphasised a significance level of p=0.05 in the Methods section and now only refer to evidence in the Results section meets this threshold. We agree that weak evidence should not be emphasised. As such, we have changed the sentence to:

“Analyses of first compulsory admission compared to readmissions indicated no significant subgroup differences” (Compulsory admission section in the Results, paragraph 2, line 4, page 9). We have also removed previous references to repeat admissions as significantly higher for Black people in the abstract, discussion and conclusion.

8. Results: p9: Same para, penultimate sentence beginning "Compared to the White reference" - please make this clear you mean "elevated rates" of compulsory admission.

Thank you, the sentence has been amended as suggested to:

“Compared to the White reference group, there were elevated rates of civil detentions for Black Caribbean (OR 3·43, 95% CI 2·68 to 4·40, n=18), Black African (OR 3·11, 95% CI 2·40 to 4·02, n=6) and Black British people (OR 2·04, 95% CI 1·11 to 3·75, n=1); this was also the case for forensic detentions for the Black ethnic groups (Black British OR 7·48, 95% CI 2·22 to 25·20, n=1; Black African OR 3·21, 95% CI 1·08 to 9·51, n=1; Black Caribbean OR 2·52, 95% CI 1·54 to 4·13, n=2).” (Compulsory admission section in the Results, paragraph 2, line 5, page 9).

9. Discussion: p13: "...perceived greater risk and consequent need to more immediately 'cure' ethnic minority people...". This feels like it needs greater discussion, or removal from the
manuscript. Perceived by whom, for whom? Is this in specific reference to the South Asian group (as the previous sentence implies) or all ethnic groups? Is this perceptions of the community around people with psychosis, or perceptions of psychiatrists, police and judicial services?

We agree that this is unclear and as our analyses do not provide clear evidence of what people in the pathways to care think about risk or need for care, we have removed this sentence rather than to explain it further/speculate on this without sufficient empirical evidence.

10. Discussion: p15: "…over many centuries for ethnic minority people". Please provide a reference to support this.

Thank you, this was a typo, we actually meant ‘decades’ rather than ‘centuries’. We have corrected this error in the manuscript.

To support this, our included references cover the time period between 1984 and 2017. We have now included the references to the individual studies that show significantly higher rates over time for ethnic minority people compared with the White reference population, as well as to previous meta-analyses making the same observation, at this point in the manuscript (i.e. Implications for research section in the Discussion, page 16).

Reviewer #2: This paper confirms the longstanding and well-documented evidence on racial disparities in mental health. It appropriately points to the persistence of these inequalities.

The paper is well-written and the statistical analyses are presented in an accessible manner.

We would like to thank the reviewer for this positive feedback on our paper.

The discussion could be more robust - the paper will benefit by some exploration of the possible explanations for the persistence of racial disparities in mental health. It is vital to present this in the context of the structural location of Black and Minority Ethnic communities. The impact of austerity on these communities have been documented by the Runnymede Trust and could be referenced here. The Prime Minister's report on racial disadvantage could also be referenced.

The recommendations seem to be aimed at Policy Makers - we know that previous Policy (e.g. Delivering Race Equality) had little or no effect. I suggest that the recommendations need to be framed in the context of the structural issues for BAME communities, including institutional racism, lack of culturally competent institutions, etc. This will make the recommendations more credible.
Thank you for these helpful suggestions. We have amended the discussion (Implications for policy and practice section, page 17-18) as suggested by this reviewer:

“Policymakers and practitioners will need to consider how ethnic variations in pathways to mental health care reflect societal, institutional and interpersonal disadvantages, including racism at each of these levels. Institutional racism often receives less attention than more overt incidents of racial prejudice and racial violence, and some critical voices have even denied the relevance of ‘race’ and racism [74]. However, it is important to recognise how racism operates within and across societal institutions and acts as a fundamental mechanism driving and sustaining inequalities. Racism reflects power dynamics in broader society that are embedded in mainstream institutions over time, shaped by the historical and contemporary inequalities in access to social, cultural and economic resources by racial or ethnic background [75, 76].

A limited number of relevant programmes championing reform and ‘race equality’ in the NHS, such as the 2005 Delivering Race Equality programme, have contributed to learning about barriers and facilitators to service access, but they have done little to achieving wider systems changes or to reduce ethnic inequalities in detention rates [15]. More recently, the Prime Minister’s Race Disparity Audit highlighted broader ethnic inequalities, for example in relation to education, the labour market and housing [1]. However, it did not examine how these inequalities can be intensified in times of economic recession and through hostile political ideologies. A recent report showed the particularly adverse effects of the extensive cuts to welfare benefits and health and other services that have occurred since 2010, on the lives of disadvantaged ethnic minority communities [77]. Although our analyses showed persisting, but no significant worsening inequalities in pathways to mental health care, the more prolonged manifestations or ramifications of the current political climate may be yet to be realised.

Perhaps the main challenge for services is how to identify and tackle institutional racism that is entrenched in the practice and principles of institutions – including their regulations, protocols, cultures and role definitions – and reinforced by stakeholders trained to behave in a compliant manner. Practitioners (mental health, social care, criminal justice) are likely to have internalised the expectations of how to operate within their institutions to such an extent that they unwittingly perform their duties without fully considering how they might sustain inequalities [75, 76].”

For references to the above section, we had previously referred to the Prime Minister’s Race Disparity Audit (ref. 1) and the evaluation of the Delivering Race Equality programme (ref. 15) in our Introduction, so we have used the same reference here, but we have also added the following references (ref. 77 being the Runnymede Trust report suggested by the reviewer):

