



## opinion & debate

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### Institutional racism in British psychiatry<sup>†</sup>

How racist is British psychiatry? Why does psychiatric practice in this country continue to discriminate against Irish, Black and Asian people? How do we, as a profession, respond to the charge of institutional racism, increasingly accepted as a major problem within British psychiatry?

Although the debate about race and psychiatry is as old as psychiatry itself, it is only in the past three decades that the psychiatric institutions and practices in this country have come under critical scrutiny for their racial bias. During this period, much has been written about the experience of Black and other ethnic minority groups within psychiatry and the tacit acknowledgement that there is a problem about race within British psychiatry appears to be shared by psychiatrists in general. There have also been many attempts in recent years to make mental health services more culturally aware and sensitive. How we provide better services for Black and other ethnic minority groups has become a service priority in many areas.

Despite the commitment by both professionals and managers to provide ethnically sensitive and culturally appropriate services the overall experience of psychiatric services by Black and South Asian people in this country remains largely negative and aversive. The disparity between ethnic minority groups and White people in service usage, service satisfaction and outcome persists with little to suggest that the situation is likely to change. In fact, there is no single aspect of contemporary psychiatric care within which Black or South Asian people are not disadvantaged.

One conclusion that we can draw from all this is that the various changes and innovations around 'ethnically sensitive services' have largely failed to address problems with race and psychiatry. Perhaps the practical emphasis placed on improving services for particular ethnic groups has distracted us from the more fundamental but also the more difficult task of addressing racism within psychiatry. In other words, until we begin to address racism within psychiatry, in its knowledge base, its historical and cultural roots and within its practices and procedures, we are unlikely to achieve significant progress in improving services for minority ethnic groups.

Clearly, there is some urgency in addressing the extent and nature of racism within British psychiatry. The publication of the Inquiry by Sir William Macpherson

(Home Office, 1999) into the death of the black teenager Stephen Lawrence, almost 2 years ago now, with its far reaching conclusions about institutional racism within public bodies in this country has, in many ways, made it easier to talk about race and racism. Macpherson started a learning process for the country at large and, in the course of it "the gravitational centre of race relations discourse was shifted from individual prejudice and ethnic need to systemic, institutional racial inequality and injustice" (Sivanandan, 2000). There is now a sense of urgency in tackling racism within public bodies such as the NHS, if the pronouncement from the government and many public bodies following the Macpherson report are anything to go by. For the first time in many years it would appear that there exists a political climate that allows us to acknowledge the existence of racism not just at the personal level but also as an institutional problem. In many ways the Macpherson report has set down a defining marker in the discourse about race and racism in this country.

What has been the professional response from within psychiatry to Macpherson and the surge of policy initiative in its wake? Sadly, and perhaps predictably, the College and other professional bodies in mental health have so far avoided any serious discussion about the implications of the Macpherson report or rethinking our current strategies on race. Meanwhile, another inquiry into the death of a Black man in psychiatric custody begins and a new generation of Black people are inducted into institutional care, mainly from our inner-cities. Given the government's modernising agenda for the NHS with its emphasis on equality and fairness, we may find that we have little choice but to discover a new but critical capacity to talk about race and racism and consider how we are to respond to the charge of institutional racism within psychiatry, like in any other public institution in this country.

Of course, critical self-examination is never easy for any professional group. As physicians we would like to think that we are, in our individual actions and collective behaviour, doing what is right and beneficial for all our patients. Any suggestion that our professional interventions might be prejudicial in intent or discriminatory in their outcome is likely to be resisted. That we might be involved, even unwittingly, in maintaining institutional racism or other culturally permissible but deeply

<sup>†</sup>See pp. 248–249, this issue



discriminatory practices through our professional actions flies in the face of how we, as psychiatrists or doctors, see ourselves and claim our professional identities. However, the searing conclusions of the Macpherson Inquiry, which acknowledge the pervasiveness and significance of institutional racism in public life, make it impossible for us to continue to position ourselves outside of such social and cultural context. So far there has been little debate about what Macpherson and his analysis mean to us as psychiatrists, how 'race' and racism affect our thinking and our day-to-day practice, how institutional racism operates within psychiatry and what we must do to counter its effects in our professional practice.

Apart from the immediate and the politically determined agenda around 'race' and racism, there are larger ethical and moral questions that are relevant here. Within the current debate about the appropriateness and effectiveness of health care and health services there is a welcome emphasis on moral and ethical, as well as political, questions. For example, who gets treated and how our treatments impinge upon particular individuals are equally important questions as whether our treatments are effective and efficient (Thorncroft & Tansella, 1999). Within mental health services both sets of questions, those which touch upon the benefits or outcome of health care interventions, as well as those concerned with autonomy of the individual, consumer rights and inequities in the delivery of care, present us with greater problems than in any other health care discipline. These issues, related to the basic principles of 'biomedical ethics', respect for autonomy, non-maleficence, beneficence and justice, have been highly problematic for psychiatry partly because of the underlying contradictions within most psychiatric practice, between cure and control or care and custody. This 'problem' of psychiatry is often concealed or minimised within a professional discourse about the nature or purpose of our practice. It is only when professional and political agendas clash so obviously, as in the recent debate about the management of people with 'personality disorder', that such underlying tensions are made visible.

However, it is in the experience of contemporary psychiatry by minority ethnic groups in Western Europe that these ethical dilemmas of psychiatry and the contradictory ideologies within mental health are made most explicit. Not surprisingly, perhaps, issues of race and culture in relation to psychiatry are rarely addressed except in the most marginal terms, invariably disconnected from the mainstream. Before long, however, all this might change, given the likely adoption of the Race Relations Amendment Bill, currently going through the committee stages in the parliament. This amendment to the Race Relations Act of 1976 will make it incumbent upon all public services to root out indirect as well as direct discrimination. For the first time, mental health services will be obliged to give serious consideration to what many Black and other ethnic minority service users and the Black communities have been saying, that there is something fundamentally wrong with the practices, procedures and underlying assumptions of psychiatry and

that modern British psychiatry is, like many other public institutions, imbued with racism.

The evidence, which attests to the discriminatory nature of psychiatric care in this country, is incontestable (Cochrane & Sashidharan, 1996). The negative experiences of psychiatry for Black and other minority groups were first documented in the early 1960s when research pointed to the over-representation of Black people within institutional settings. Since then a wealth of data have emerged that clearly confirm that Black and other minority ethnic groups experience psychiatry differently from White people, and that such discrimination extends to all aspects of psychiatric care. Without exception the evidence base to data in this area shows that ethnic minority groups have an overwhelmingly negative experience of psychiatry.

Until recently the central theme in any debate on ethnicity and mental health has been one of differential representation within psychiatric services. This is based on the observation, derived from conventional research studies as well as the experience of those working within mental health settings, that people from African or African-Caribbean backgrounds (as well as people of Irish origin) are overrepresented and people from Asian backgrounds are likely to be underrepresented in psychiatric settings. Although recent research points to a more uniform pattern of inception into psychiatric care for all patients from ethnic minority backgrounds (King *et al*, 1994) the essential argument remains the same, that ethnic minority groups are differentially represented within psychiatry. Such ethnic minority groups (always using the native-born White group as the norm) found in the rates of hospital admission, referral rates to secondary care settings and detection rates of mental disorder in the primary care settings could be explained as owing to differential affinity to psychiatric services between ethnic groups, but also the increased risk of diagnostic misattribution in minority groups in general when compared to the White people.

What should interest us here is that, within psychiatric practice, minority ethnic groups continue to be deemed as deviant from the White norms one way or another, either as requiring or receiving too much or too little psychiatry. Even after accounting for factors that normally explain discrepant rates for treated morbidity, there is an excess of minority groups at either end of the care spectrum, either receiving extreme forms of care or no care at all. Obviously, much of the debate in this area has been about the overrepresentation of Black people within psychiatric care (or, to be more precise, within institutional settings of psychiatry) but the argument is the same whether people from minority groups are more or less likely than White majority to be seen as requiring mental health care and the attendant professional attention.

The message is unambiguous; minority groups are represented within psychiatric settings in a different way, both quantitatively and qualitatively, from the White majority. There are two ways of addressing this apparent discrepancy in the representation of ethnic minority groups within psychiatry. The first is based on the notion



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of disease variability, that is, ethnic minority groups have higher or lower rates of mental illness compared to White people, and that psychiatric services show a different pattern of service usage as a result. The second explanation is based on the view that such variations in service use are fundamentally to do with how European psychiatry discriminates against Black people.

Attempts to explain these discrepancies in the care patterns found in the ethnic minority groups, based on differential rates of illness, cultural factors or individual or personal prejudices of mental health workers, have been largely unsuccessful. Not only that, the preoccupation with ethnic vulnerability, as the major explanatory variable to account for the discrepant patterns of psychiatric care, has also prevented a closer examination of the procedures, practices and theoretical underpinning of most of modern psychiatry. In practical terms, our collective inability to address and change the iniquitous nature of psychiatric experience by ethnic minority groups can be attributed, at least partly, to the academic agenda within psychiatry over the past 50 years or so, which has been fixed around differential disease rates and the study of race differences, an idea that can be traced back to the origins of 'race' science in 18th century Europe. For example, over the past 20 years or so, the whole debate around schizophrenia and Black people in the UK bears the hallmarks of such a legacy. Unfortunately, there is little evidence that such professional preoccupation is beginning to diminish, despite our failure to identify any 'ethnic' factors in the causation of mental illness, although much effort and a great deal of money continue to be expended in this futile search for 'Black schizophrenia'.

Although this particular seam of psychiatric research has yielded little of value, either in terms of understanding the causation of schizophrenia or in providing any meaningful insights into the experience of ethnic minority groups in this country, such has been the academic preoccupation with this theme over the past two decades that it is, perhaps, understandable why psychiatrists continue to address 'ethnicity' or 'race' in terms of whether Black people are more or less vulnerable, compared to the 'normative' White groups, to developing schizophrenia. While the parallels with an earlier debate in social and psychological sciences around IQ and 'race' are obvious in this context, the lessons learned from that chastening chapter within European science continue to be glossed over or ignored when considering mental disorder.

It is important to move beyond such sterile (and, ultimately racist) theorising and academic agenda if we are to gain a meaningful understanding of how 'race' and racism operate within contemporary psychiatry. To achieve this, we will have to appreciate how psychiatric institutions and psychiatric practices impinge upon disadvantaged or marginalised groups in our society in general and minority ethnic groups in particular. Psychiatric practice affects such groups adversely, in respect of their actual experience of psychiatric care and, more generally, the outcome of psychiatric interventions. In relation to Black and other ethnic minority groups in the UK, for example, conventional epidemiological and clinical

studies repeatedly point to the discriminatory nature of the psychiatric care received by them (Commander *et al*, 1997). The increased risk of coercive psychiatric interventions in the pathway into psychiatric care, the discrepancies between ethnic groups in assessment and identification of needs and risks, the nature and location of psychiatric treatment and differential outcome have all been identified time and again in such studies and, furthermore, these issues continue to be the subject of a number of local and national enquiries and reports (National Schizophrenia Fellowship, 2000; Warner *et al*, 2000). The testimony of Black patients and carers and the perceptions of the Black communities also appear to be consistent with this general theme that there is no aspect of contemporary psychiatric care that favours Black people when compared to White patients and, in overall terms, psychiatry, like policing, the criminal justice system, educational institutions and social work, militates against the interests of Black people in this country. The argument is no longer about over- or underrepresentation of Black people and other ethnic minority groups within psychiatry, but how such communities experience psychiatry and why such experience is largely negative and discriminatory in nature.

On the basis of this analysis it is easy to understand why the accusations of racism or racial discrimination are difficult to set aside. The claim that psychiatry operates in much the same way as any other aspect of medicine, that the ethnic variations are merely products of differential disease burden, is unsustainable when the actual service experience of Black people is so imbued with negative stereotypes and high levels of dissatisfaction and resistance. If an organisation or an institution, such as the contemporary mental health system, through its activities produces such discriminatory patterns of experience or outcome that clearly and unremittingly disadvantages minority ethnic groups, the charge of institutional racism that comes in its wake is difficult to ignore.

As the Macpherson Inquiry found, even in the absence of evidence of direct racism, indirect discrimination exerts a profound effect on how Black people are treated and how they perceive and experience the institutional agency. Where minority groups experience discrimination, whether overt and intentional or disguised but deliberate or, as would appear to be the case in mental health, unintentional but adverse, the charge of institutional racism will have to be taken seriously. The last of these creates the greatest difficulty, where rules or practices apply equally to everyone but have a disproportionate and adverse impact upon a particular racial or ethnic group. However, even where practices and policies are seen as fair in a formal sense but discriminatory in their operation and effect, there will have to be some urgency in identifying how this comes about as well as seeking effective remedies in dealing with such racism.

We have to address the challenge of institutional racism within contemporary psychiatry in this context. There is little credence to the argument that what happens to Black and minority ethnic groups within mental health services is simply a product of individual racism or, for that matter, a consequence of cultural



ignorance on the part of the practitioners. The problems run much deeper than that. The roots of racism within psychiatric care can be traced to the conceptual and theoretical framework of what constitutes modern psychiatry (Littlewood & Lipsedge, 1982; Fernando, 1988). The nature of psychiatric practices and procedures that arise from such a knowledge base as well as professionally sanctioned activities around social control have become fundamental to what constitutes mental health activities. Experience of psychiatry is centred on these 'social control' issues because it is here that the consequences of discriminatory practice (Mental Health Act, custodial and compulsory care, use of medication, lack of after-care) are most visible and where psychiatry seems to operate in a similar way to the police or the prisons. In many ways it would be possible to challenge and even correct such discrepant and discriminatory practices, for example by setting targets for providers and creating alternative and community-based services, assuming that there is political will and professional commitment, both of which have been lacking so far. A far bigger challenge will be to address the cultural and historical specificity of psychiatry, in particular the theoretical underpinning of diagnosis and classification. The related ideology around causality, vulnerability and the emphasis on racial as against social, material or cultural factors also demand reappraisal, given their cultural and historical roots.

It is unlikely that significant changes will come about simply as a result of changes in individual practices or through professional training on cultural or race awareness. Nor does the answer lie in developing segregated services with its emphasis on ethnic matching between service providers and users (Bhui *et al*, 2000). History and experience show that any challenge to institutional racism, if it is to be successful, will have to start with a clear acceptance of the intent and nature of the problem and a commitment to defeat racism. Sadly, at present, there is little evidence that either our profession or the Department of Health has woken up to this challenge, although the latter has at least acknowledged institutional racism as a key factor in explaining the current inequities in mental health. Along with a commitment to change the coordinates of psychiatric practice through the development of a variety of community-based options, there will have to be a national strategy for Black mental health. It is deeply dismaying that the opportunities available at the time of the new *National Service Framework for Mental Health*, to develop a coherent set of principles or standards as applied to minority ethnic groups, were ignored and, as a consequence, there is relatively little attention to racism or discriminatory practices within the mental health agenda locally or nationally. A coherent and overarching national strategy for mental health and minority ethnic groups, with a clear mandate to tackle institutional racism within mental health services, will be the first step in the fight against racism in psychiatry.

Sadly, the professional response to the evidence, which has accumulated over the past three decades, attesting to the extent and consequences of racism within psychiatric services, has been no different to that of other institutional agencies when faced with similar challenges. The College, in spite of its various committees on race, ethnicity and social and transcultural activities, has so far shown little inclination to address this issue, let alone provide any kind of leadership or professional backing to campaigns initiated by the Black communities. As with other significant changes that are taking place within mental health services as a whole, the College runs the risk of being left behind on this issue unless there is some indication that we are beginning to grapple with what the Black communities and service users have been saying for decades and acknowledge the post-Macpherson realities and the challenges posed as a result. Our ability to influence change and sustain professional credibility in responding to the needs of minority ethnic groups depend on the political will and professional commitment that we show in tackling racism within our profession and our day-to-day practices.

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