opinion & debate

the ball; all the evidence suggests that Black people and many people from other minority ethnic groups are being admitted to and detained in psychiatric hospitals either unnecessarily or at disproportionate rates. Psychiatry and psychiatrists are only one part of a complex organisational response to mental disorder; it is the (possibly) discriminatory response of that complex structure which is at issue, not the views of individual psychiatrists. We must focus on the underlying reasons, whatever those are, and try to understand the multifactorial interrelated issues which lead to the heightened admission and detention rates for some groups in society.

Declaration of interest

K.P. is Chairman and C.H. Chief Executive of the Mental Health Act Commission.

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KWAME McKENZIE AND KAMALDEEP BHUI

Better mental healthcare for minority ethnic groups – moving away from the blame game and putting patients first: Commentary on . . . Institutional racism in psychiatry†

Providing better mental healthcare for the Black and minority ethnic population often requires much more than the efforts of the individual clinician. Problems may range from getting the right interpreters when they are needed, for as long as they are needed, to accessing psychotherapy and social service help for refugees and asylum seekers. Most of us have little training in negotiating differences in illness models, diagnostic labels and preferred pathways to care and treatment for a multicultural society (Department of Health, 2005).

All of these difficulties and more are reflected in the literature on disparities in care between ethnic groups in the UK (Sashidharan, 2003). These problems are not the fault of clinicians but reflect the need for a concerted, coherent effort at an institutional level. Those using the institutional racism paradigm to understand disparities and develop solutions focus on systems not individuals (McKenzie, 1999). Tackling these disparities requires institutions to take responsibility for producing an environment that develops and supports sustainable, effective, ethical interventions targeted at delivering equitable services. Unfortunately, when institutions are challenged to do this they often do not take responsibility.

> 'We just don't believe that "institutional racism" would be a helpful label to apply – the solutions lie in the hands of individuals, not institutions' (Department of Health Media Centre, personal communication 2007).

We do not agree with this proposition. Individuals cannot conjure up adequate interpreting services or more trauma therapists. Such solutions are not in the hands of the individual and the issues are not explained by individual racism.

These problems are seen repeatedly. Suicide by African–Caribbeans who are in contact with mental health services is one example. Research in the 1990s had shown that those with a diagnosis of psychosis have a five times lower risk of self-harm and suicide (McKenzie *et al*, 1995) but in 2003 McKenzie *et al* reported that young African–Caribbeans had the same risk as British Whites. The National Confidential Inquiry has stated that clinicians in charge of the care of African–Caribbeans who have died by suicide are more likely to report that they believe this could have been prevented (Hunt *et al*, 2003).

We do not think it would be at all helpful to point the finger at individual clinicians. Preventing suicide is difficult and requires a wide-ranging strategy. Mental health professionals are as good as the systems that they work in and the body of knowledge they have. Practice needs to be revised as new knowledge and interventions emerge. Dealing with the issue of African–Caribbean suicides may require research, training, the production of culturally valid risk assessment tools, service development in the statutory and non-statutory sectors and a public awareness campaign. Most other reported disparities require similar in-depth analysis and an institutional response.

We all know that despite our best efforts some ethnic groups do not get equitable mental health treatment. This is backed by clinical experience and research

†See pp. 363–368, 370 and 397–398, this issue.

opinion & debate

(Sashidharan, 2003; Department of Health, 2005). The broad consensus on this issue has led to the development of a national strategy, Delivering Race Equality, which has been agreed by user groups, community groups, the voluntary sector, social services and health services (Department of Health, 2005). Delivering Race Equality was built on a prevoius report *Inside Out* which the public and patients helped to formulate (Sashidharan, 2003).

Delivering Race Equality has the commitment of clinicians, managers and leaders throughout the National Health Service and social care world. It will lead to real improvements in services as long as it continues to be supported. It is a progressive policy of which we can be proud and is contributing to the cuttinge-edge international debate on culture and mental health (Bhui *et al*, 2004; Bhui & Bhugra, 2007).

However, moving from policy and consensus that there should be change to actually implementing sustainable service development in mainstream mental health services can be difficult. Research has demonstrated that using the fact that institutions have duties under the Race Relations (Amendment) Act 2000 is an important driver for producing equal public services for Black and minority ethnic groups (Audit Commission, 2003). The Audit Commission (2003) also states that this should be coupled with an understanding of institutional racism.

Unfortunately, when this strategy was used under the Delivering Race Equality initiative some clinicians felt threatened and misunderstood it as an attack on psychiatrists. This was perhaps partly because of the potential for performance management and regulation around race equality and partly because of the results of the Count Me in Census (Healthcare Commission, 2005). These worries have been played out in emotionally charged personal narratives that have been fused with academic findings and debate about the causes of the increased incidence and section rates in the African–Caribbean population (Singh & Burns, 2006; McKenzie & Bhui, 2007 and related correspondence). Areas of conflict have been reported where none exists. At times it is as if 'straw man' arguments are being set up just to be knocked down.

We believe very strongly that there is more agreement than disagreement in this area and that the disagreements have been blown up out of all proportion. We do not see the point of perpetuating 'straw man' debates as these detract from the work that needs to be done in improving services. It also detracts from the fact that there is a consensus that the disparities reflect complex problems that need complex solutions, and that we should not distort the priority of improving services for all Black and minority ethnic groups that suffer poorer treatment by focusing on one problem in one ethnic group.

If the aim is to improve services for patients we need to be working together. The single common pathway for improvement of care should be an agreement that:

- patients come first
- we improve on what we have got rather than inadvertently undermine it
- we deploy approaches based on all forms of evidence and respect the views of users, carers and communities
- we focus on solutions
- we are committed to the long-term processes that are necessary rather than short-term missions.

Being able to deliver services for a multicultural society requires a significant strategic multidisciplinary effort at a number of levels (Bhui & Olajide, 1999; Bhui, 2002). Many of the problems we face in doing this are a consequence of policy, decisions made by institutions and the wider social determinants of health. If we want to deliver better services for our patients we need a united effort which respects different points of view and considers them as part of one jigsaw. We need to focus on our areas of agreement and build on these rather than permit digressions due to philosophical and political differences, because that path will not deliver for the people who really matter.

Declaration of interest

K.M. and K.B. are members of the Ministerial Advisory Group on BME Mental Health and K.B. is Chair of the Transcultural Special Interest Group in Psychiatry, Royal College of Psychiatrists.

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