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# Institutional racism in psychiatry: lessons from inquiries†

'While everyone is entitled to their own opinions, they are not entitled to their own facts' (attributed to Daniel Patrick Moynihan).

The President of the Royal College of Psychiatrists recently reiterated the College's determination to tackle institutional racism in psychiatry, as defined in the MacPherson Report (MacPherson, 1999). This reaction was prompted by a paper suggesting that racism was perhaps not the only explanation for ethnic differences in rates of psychosis and detention under the Mental Health Act 1983 (Singh & Burns, 2006). Although not providing a scientific criticism of the *BMJ* paper or any evidence to the contrary, the President stated that the paper risked setting 'psychiatry back by 20 years' (Hollins & Moodley 2006).

The MacPherson Report defines institutional racism as 'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people'. The report found institutional racism in many aspects of the Stephen Lawrence case, including the conduct of the investigation, the family's treatment, the failure to recognise the murder as racially motivated, and the lack of urgency and commitment in the investigation.

## Racism in mental health services

How would similar failures manifest in mental health services? A person from a minority ethnic group who has a serious mental illness is not given an adequate diagnosis, not provided with a coherent treatment plan, not offered appropriate treatment and does not have their needs met. Such failures occur repeatedly over many encounters with the services, and several clinicians individually and collectively contribute to the poor decision-making. These experiences are replicated nationally for patients from minority ethnic groups.

## Lessons from inquiries

Sadly such a scenario is not merely hypothetical. Another high-profile inquiry did indeed find collective failures in psychiatry to provide appropriate service to an individual from a minority ethnic group. The Ritchie Inquiry into the care and treatment of Christopher Clunis (Ritchie *et al*, 1994) recorded a catalogue of similar shortcomings. From his very first contact at Chase Farm Hospital where 'the opportunity for early diagnosis and possibly effective treatment was lost' (p.14) to a desire by social workers 'not to stigmatise a patient, or label him in any way as violent or a difficult person, which it was felt might work to his disadvantage' (p.19), the care provided to Christopher Clunis gives salutary lessons on what happens when objective clinical assessments are made subservient to socio-political concerns. The tragic outcome was not the result of any one single decision or process, and other factors also contributed, including inadequate resources and follow-up arrangements. But the inquiry made it clear that there was a tendency among staff repeatedly 'to postpone decisions or actions when difficulty was encountered or perhaps because the patient was threatening, and intimidating, and possibly because he was big and black' (p.107). The consultant psychiatrist involved in the initial management told the inquiry that Clunis 'was probably suffering from a degree of depression'. This indeed is institutional racism, the risks that many from minority ethnic groups face within psychiatry: of not being given the correct diagnosis and not being treated assertively enough, simply because of their ethnicity.

## Institutional racism experts

A recent editorial in the *BMJ* claimed that in psychiatry the higher rates of psychosis and detention for some minority ethnic groups are equivalent examples of institutional racism (McKenzie & Bhui, 2007). Specifically, the paper argued that 'these disparities reflect the way health services offer specific treatment and care pathways according to racial groups, and therefore seem to satisfy the well established and widely known definition of institutional racism'. This statement presupposes that treatments are in reality offered on the basis of racial groups and disallows the possibility that ethnic differences might exist because of other societal, 'upstream' factors, which may not be within the control of health services. Moreover, it does not consider the possibility

that care pathways are not always 'offered' by health services but are sometimes chosen, and sometimes imposed upon patients by legal processes, outside of the control of healthcare services. The paper further suggests that the term 'institutional racism' is used by these experts in a sophisticated and nuanced manner and is not meant to suggest that individual clinicians are racist. Services should therefore not 'shoot the messenger' but rather embark on the 'painful process' of self-scrutiny. This is sophistry. I have been to several meetings for Black and minority ethnic groups where services are labelled racist in the everyday sense of the term, often to loud applause from the experts themselves. Indeed, reports such as *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (Sashidharan, 2003) continue to state unequivocally that patients from minority ethnic groups are 'misdiagnosed', 'more likely to be prescribed drugs and ECT' and that 'their rights and health care needs are less likely to be taken seriously' (p. 13). The foreword to *Delivering Race Equality in Mental Health Care* begins with the sentence 'there is discrimination, both direct and indirect, in mental health care' (Department of Health, 2005: p. 9). It is disingenuous to claim that institutional racism is understood at the level of the clinical encounter by anyone in any sense other than as overt, racist discrimination.

There is another more serious concern about how the 'evidence' for the charge of institutional racism is presented. In the David Bennet Inquiry (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) all external experts agreed unanimously that institutional racism exists in psychiatric services in the UK. The *Inside Outside* report also emphasises that 'we must begin by acknowledging . . . that institutional racism exists within mental health care' (Sashidharan, 2003: p. 7). This is not a dispassionate effort to explore a complex issue with evidence presented and weighed for and against a hypothesis. It is akin to a judicial process where only the prosecution case is presented and the accusation therefore validated simply by being made.

## The way forward

In the UK there are ethnic disparities in the prevalence and management of diabetes, coronary artery disease, hypertension, cataract surgery and hip replacement, as well as serious mental illness. There is little debate about the role of racism in these differences and even less a demand that, for instance, the high rates of coronary artery bypass among Asians be reduced to ensure ethnic parity with Whites. We would not consider blaming hospital physicians for the rising rates of obesity in the population.

Undoubtedly the structure and process of care provision in psychiatry is different because individuals can be treated against their will. This is inherent in the nature of the phenomenon itself; no amount of tinkering with language will change the fact that some people will not accept treatment voluntarily and will therefore always be unhappy with the coercive nature of interventions. The only way to stop all coercion is to stop treating people against their will, regardless of clinical need. As soon as we accept that in some cases patients will not accept the diagnosis or the treatment but still need it, we introduce coercion. We should therefore pause and reflect before heaping opprobrium on the very people providing much needed help and care for those with mental illness. Services are usually under-resourced and understaffed in areas where there is a preponderance of minority ethnic groups: that is, in run-down, impoverished inner-city areas. Staff in such services need our support for doing a difficult job in difficult circumstances, not our disdain for failing this or that group.

Where services have failed it is because they have done too little, not because they have done too much. Examples of such poor care, as evidenced by the Ritchie Inquiry (Ritchie *et al*, 1994), have mostly been a result of a failure to make early diagnosis, conduct adequate risk assessments and a reluctance to assertively engage and follow-up patients, especially those from minority ethnic groups. Although it is important to be aware of and be sensitive to cultural issues, we must not treat our patients as members of groups rather than as individuals. This is what racists do. If culture is important, it is important in everyone: for a person recently arrived from Latvia, a White person from a deprived northern town and an asylum seeker or a second-generation immigrant from Asia or Africa. Good psychiatrists have always taken cultural and ethnic factors into account when dealing with their patients; the art of psychiatry requires the ability to synthesise individual, cultural, biological, psychological and social influences into a coherent whole that we call a 'case formulation'. The Bennet Inquiry recommended mandatory training for all managers and clinical staff in all aspects of cultural competency, awareness and sensitivity (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003: p. 67). This is a laudable aim for the multicultural and diverse Britain that we now live in. Will this reduce rates of psychosis and detention in some groups? If not, then should we not decouple the arguments about diagnosis and detention from the need for cultural awareness? A witness to the Bennet Inquiry summed up this confusion between minor failings in services with the tragic outcome by asking 'how much cultural awareness training does a nurse require before they realise that too much force will kill' (McLaughlin, 2007).

By focusing inappropriately on culture and ethnicity at the expense of sound clinical judgement, we risk offering poorer rather than better care to patients from minority ethnic groups. We also do not need to see culture as an impermeable, static barrier between people, which if breached will lead to conflict or misunderstanding. Our shared humanity and the commonality of human suffering, pain and loss should allow us to understand the influences of culture without demanding that patients from minority ethnic groups be treated in a fundamentally different way. In my very first year as a psychiatrist in the UK, a White woman with depression post-mastectomy refused to see me because she felt that someone from my 'culture' would not be able to

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understand her. I wrote to her asking her to see me first and then decide whether I could help her or not. She did and we had a successful therapeutic relationship over time. Now when I read of demands for 'culturally separate services' (Bhui & Sashidharan, 2003), I feel that my White colleagues are being told: I am equal to you but you are not equal to me.

The debate has so far been conducted in a Black and White manner, with psychiatrists seen as oppressors and patients as victims. People drawing such caricatures see themselves as the moral guardians of public institutions, combating the evil of racism in all its forms. They have two great advantages over practising clinicians. First, many of them have no responsibility for providing care. Such power without responsibility must be exercised judiciously, especially when the welfare of the vulnerable is at stake. Those who do practise psychiatry while berating it for being 'eurocentric' and racist, never provide alternatives of proven efficacy to standard psychiatric care. Second, vested interests are supposed to reside only within the psychiatric sphere. No one questions the vested interest involved in high-profile committee memberships, the academic kudos and other trappings of power acquired simply by making allegations against psychiatry which cannot be defended, because to even challenge a charge of racism is to display racist tendencies.

If our patients are to receive the care they deserve, we need to make sound clinical judgement, free from bias and political fashion, the bedrock of our practice. Scientific evidence must be the basis on which we devise our treatments, not ideologies, especially those that are not penetrable by facts. Our patients are individuals with their own personal strengths and vulnerabilities, and must not be reduced to ideological battlegrounds where political and cultural wars are fought. Moreover, if psychiatry is to get the leadership it deserves, perhaps we should all speak out when we feel that scientific objectivity and clinical reasoning are being made subservient to political considerations and expediency.

## Declaration of interest

## Acknowledgements

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# Searching for racists under the psychiatric bed: Commentary on . . . Institutional racism in psychiatry[†]

In our view, Professor Singh's article (2007) is one of the most important papers to appear in the *Bulletin* in recent years. Singh & Burns (2006) have been very courageous in challenging the idea that British psychiatry is institutionally racist, and not unexpectedly have provoked reaction. What has been more surprising is the extent to which this has provoked strong criticism of Professor Singh among psychiatric colleagues.

Over the past 15 years, there have been at least nine reports from government and voluntary agencies on the high rates of psychosis and compulsory detention among African–Caribbean people living in the UK. Psychiatrists have striven to divest themselves of any hint of racism in their practice, and cultural training has become mandatory for all staff. Yet the high rates persist, even in trusts where White English-born psychiatrists and nurses are in a minority. Importantly, the clamour about institutional racism has obscured the real causes of the increased incidence of schizophrenia and mania among British African–Caribbeans. Sadly, therefore, appropriate action

[†]See pp. 363–365, 367–370 and 397–398, this issue.

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