editorial

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Services for ethnic minorities: a question of trust

SUMMARY

Mental healthcare for ethnic minorities is a government policy priority. However, debate about how services should develop has been overshadowed by public criticism over high rates of admission and sectioning in some ethnic groups, the implication being that racism is rife in mental healthcare. These criticisms are headline-seeking, scientifically crude and unfair to mental health professionals. However, it is true that some minority communities are mistrustful of the services available. We need to overcome this mistrust with a positive message – and a promise of fair treatment.

In my 8 years working with the government, there are few areas of policy that have been as controversial as race equality. Yet the aim is one that few people could disagree with – to develop mental healthcare for a diverse society, with its rich mix of cultures, races and religions. There is reasonable agreement on what is needed – staff training, closer links between services and the communities they serve, better information.

The arguments, though, are not about aims or methods. They are about the analysis of the problem and the public messages that have been attached to it.

Psychotic illness, like heart disease and diabetes, does not occur equally in all races. There are high rates in minority and migrant groups across the world and in the UK rates are particularly high in people of African and Caribbean origin. The apparent reasons do not reflect well on British society because they lie in the nature of ethnic minority experience in this country – urban poverty, educational disadvantage, racism – and social adversity whose effect is so pernicious that it can trigger severe mental illness, whatever the biological basis may be.

You would think that this analysis would be seized upon by people who are concerned about racism. After all, it spells out a stark message – the discrimination that many ethnic minorities suffer is not just wrong, it also makes them ill. A fair society would also be a healthier society.

Yet there is a body of opinion that rejects this explanation for the high rates of mental illness in minority and migrant groups. For some, this is not a stark message but a soft option, because it lets mental health services off the hook. If the high rates of psychosis are explained by factors in broader society, and if the rates of sectioning under the Mental Health Act are mainly a reflection of the rates of illness, then it must be wrong to blame mental health services. For some, blaming mental health services is a habit that is hard to break.

Mental healthcare, and the people who work in it, have been the traditional target of criticism in this area. High rates of illness and sectioning, it is simplistically assumed in the media and elsewhere, are the product of inappropriate practice on the part of mental health professionals although no one has ever shown that the Mental Health Act is used inappropriately in individual cases. Charges of 'institutional racism' are made and whatever subtleties are contained in the original definition of institutional racism in the MacPherson inquiry report, it has too often come to mean something else – racist behaviour that is not only ingrained and pervasive but deliberate.

It is of course reasonable to ask whether clinicians may be influenced by the social stereotypes that are arguably found in other walks of life. Can we as psychiatrists be certain that we do not see the young man with psychosis as more dangerous – and so more clearly sectionable – if he is also Black?

Mental health services may not be the malign cause of the reported rates of psychosis in ethnic minorities that some people accuse them of being but that does not mean they are off the hook because they are crucial to the solution. It is up to us to examine our attitudes and assumptions about patients from minority groups and to take up training in what is nowadays called cultural competence. It is up to mental health trusts to connect with local communities, to achieve a better understanding of each other and, most of all, to create trust.

We have to ensure equality in mental healthcare, although we also have to be clear – equality of what? It cannot be equality of provision. If you offer exactly the same service to people whose position in society is unequal, you are perpetuating their inequality. It has to be equality of experience, and that means doing more for people who are marginal and disadvantaged through early intervention and outreach teams, for example. In

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healthcare, some people really are more equal than others.

At the heart of this issue is trust – or lack of it. I have met young Caribbean men who view mental health services as a branch of the criminal justice system, just another place where they can be held in custody. That is a terrible thing to have to admit and an urgent problem to put right.

It is not enough to say that the reality is different, that staff in mental healthcare are probably more socially aware than in any other part of the National Health Service, or to complain about press coverage. It is our job to win the trust of minority communities, so that the young Black patient no longer sees the mental health unit as a remote and threatening institution but as an accessible source of help, with a profile in the church or the youth club or the high street, so that his family, when they are worried about his behaviour, contact their general practitioner rather than the police.

This is why national policy stresses the need for links with community groups and with local leaders, spearheaded by the community development workers for whom government funding has been made available.

It is up to us to present a positive image of mental healthcare. It is equally up to those who comment publicly on mental health issues to encourage people to seek help when they need it. You cannot accuse services of being racist and then claim to be shocked when young Black people refuse the help they need.

Race equality will remain a policy priority in the next phase of mental health reform, in which the twin themes of high-quality clinical care and social justice will come together more clearly than before. This will bring a new responsibility on all of us to broadcast a more positive message to ethnic minority patients, their families and communities. That message is simple: you will be treated fairly.

Declaration of interest

None.

Reference

MACPHERSON, W. (1999) *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William MacPherson of Cluny.* TSO (The Stationery Office).

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