Race and mental health: there is more to race than racism

Swaran P Singh and Tom Burns

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outside it looks like a patchwork of mutually contradictory ideas struggling for dominance.

Contributors and sources: NH has been health editor of the *Times* since 2000 and a close follower of every twist and turn in NHS policy under four ministers. The information comes from briefings, published documents, and open literature sources but the judgments are his own.

Competing interests: None declared.

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Controversy

Race and mental health: there is more to race than racism

Swaran P Singh, Tom Burns

Some minority ethnic groups in England and Wales have higher rates of admission for mental illness and more adverse pathways to care. Are the resulting accusations of institutional racism within psychiatry justified?

Health Sciences Research Institute, Warwick Medical School, University of Warwick, Coventry CV4 7AL
Swaran P Singh *professor of social and community psychiatry*
University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX
Tom Burns *professor of social psychiatry*
Correspondence to: S P Singh S.P.Singh@warwick.ac.uk

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> It occurred to me that there was no difference between men, in intelligence or race, so profound as the difference between the sick and the well.
> F Scott Fitzgerald. *The Great Gatsby*. 1925

The "Count me in" census for England and Wales showed higher rates of admission for mental illness and more adverse pathways to care for some black and minority ethnic groups and produced predictable accusations of institutional racism within psychiatry.[1] Lee Jasper, chair of African and Caribbean Mental Health, stated: "This census confirms once and for all that mental health services are institutionally racist and overwhelmingly discriminatory. They are more about criminalising our community than caring for it."[2] In fact, the census clearly states that it "highlights the differences between various black and minority ethnic groups and the need to avoid generalisations about these groups. It does not show a failure in the services" (page 7) and comments that "although many possible explanations have been put forward for these patterns, the evidence is inconclusive" (page 27). Not surprisingly it was the accusation of institutional racism, described as a "festering abscess within the NHS,"[2] that made the headlines. Mr Jaspers is not alone in expressing such concerns. Several reports and inquiries have also alleged that psychiatry is institutionally racist.[3–6] What then, is the evidence that the census findings can be attributed to racism within psychiatry?

Rates of mental illness in minority groups

High rates of mental illness in migrant groups have been recognised and speculated on throughout the past century. A scientific approach to understanding the issue originated with Odegaard's observation of raised rates in Norwegian immigrants in Chicago,[7] and various theories have been proposed to explain this excess.[8] In the United Kingdom the argument is at its most intense around the enduring epidemiological finding of high rates of psychosis in second generation African-Caribbean patients.

IAN McLLOORM/REX FEATURES

Lee Jasper, chair of African and Caribbean Mental Health, says mental health services are institutionally racist

These higher rates have been proposed as evidence of racism on two main grounds. Firstly, that the diagnoses are mistaken, stemming from "Eurocentric" diagnostic practices; Western psychiatrists are proposed to be more likely to misinterpret behaviour and distress that is culturally alien to them as psychosis. It is unfamiliarity with culturally alien ideas and practices that leads psychiatrists to label some black and ethnic minority people's behaviour as "bizarre" or illogical (characteristics of psychotic psychopathology). In short, the patients neither have the illness nor the symptoms attributed to them but are simply misunder-

stood by intellectually rigid and inattentive professionals. The second argument is that even if the diagnosis is not that amiss the clinical response is powerfully influenced by racial stereotypes. It is argued that the compulsory detention of black patients, by itself, reflects entrenched discriminatory value judgments.

Contrary to the view that "there has been little debate" and "little inclination to address" racism within mental health services,[9] psychiatry is not complacent about these issues. Indeed, an impressive body of high quality research focuses explicitly on them. To date, no population group or culture has been identified in which psychotic disorders do not occur.[10] There are some variations in incidence and course of psychotic disorders across cultures, but what is striking is the similarity of phenomenology.[11–13] A diagnosis of psychosis is therefore not made because ethnic minority groups "deviate from white norms" or on "Eurocentric" theories or even in a "futile search for 'black schizophrenia.'"[9 14 15]

A series of UK studies has been conducted specifically to test the theory that culturally derived misdiagnosis explains excess rates of psychosis in ethnic minority patients. Using highly structured and validated research diagnostic assessments by independent raters, these studies have consistently confirmed high rates of psychosis in the African-Caribbean population (particularly second generation immigrants) and also not found any raised rate of misdiagnosis.[16–18] The excess of psychosis in the African-Caribbean community in the UK is real and well accepted by epidemiologists and researchers.[8 19]

Rates of psychotic disorder are high not just among the African-Caribbean community in the UK, they are high for all immigrant groups globally.[20] The excess is also not restricted to non-Western minorities. Rates of schizophrenia are high in migrants to Denmark from Australia and Greenland,[20] in Finnish migrants to Sweden,[21] and in Britons, Germans, Poles, and Italians who migrated to Australia.[20] Increased rates of psychosis in all migrants, irrespective of ethnicity, therefore suggests an explanation that is not ethnic specific and is environmental rather than genetic. Shared experiences of discrimination, social exclusion, and urbanicity may all contribute to this increased risk and also explain a greater increase in communities exposed to higher levels of such experiences, such as black and ethnic minority communities in the UK.[20–22] Ethnicity and psychosis is simply not a black and white issue.

Compulsory detention in minority groups

High rates of detention and adverse pathways to psychiatric care for ethnic minority patients have been confirmed in many UK studies: racism within psychiatry and racial stereotyping of such patients are the commonest explanations provided for this excess, with little evidence to substantiate or refute this claim (Greenwood et al. "Ethnicity and Mental Health Act 1983: a systematic review." Submitted to the Department of Health 2006). A study by Lewis found that UK psychiatrists rated black male patients as potentially more violent than white patients.[23] However, a similar study by Minnis conducted 10 years later reported a contradictory finding—that UK psychiatrists were more likely to regard white patients as a management problem and to pose a risk of violence to others.[24]

A recent multicentre UK study of first episode psychosis, while confirming excess detention and more adverse pathways to care for African-Caribbean patients, also found lower rates of referral from general practitioners and higher referrals from the criminal justice system.[25 26] Intriguingly African-Caribbean families were more likely to access help for an ill family member through the police rather than the medical system. Since this was a study of presentation of first episode psychosis to secondary and tertiary services, this finding cannot reflect prior experience of institutional racism within psychiatry. The authors postulate that the greater stigma of mental illness in the African-Caribbean community might act as a barrier to early help seeking until a crisis develops, when the behavioural disturbance of the illness is misconstrued by families as requiring legal rather than medical help. The excess of detention rates is less striking for Asian than African-Caribbean patients and is lower in first episode psychosis than more chronic illness (Greenwood et al. "Ethnicity and Mental Health Act 1983: a systematic review"). This strongly points towards important and as yet unexplored differences between ethnic minority groups in factors that contribute to detention. It also suggests that, over time, the relationship between ethnic minority patients and mental health services deteriorates, thereby creating a spiral of downwards engagement, in which each illness episode contributes to further disengagement and hence more coercive management strategies.

The decision to detain a patient is necessarily preceded by the patient's refusal to accept help on a voluntary basis. Hence, a legitimate question is whether some groups of patients are more likely to refuse help from psychiatric services. And if so, why? We know that individuals who have no intermediary (usually a family member) to help them access help are more likely to receive compulsory care, partly because carers may seek help early and pre-empt an acute crisis and partly because of fewer community alternatives to detention such as an extended family or support network. Other factors associated with higher detention rates—such as unemployment, living alone, low levels of social support, and non-compliance with medication—are higher in some ethnic minority groups.[27–29] Indian and Pakistani patients, while as socially deprived as African-Caribbean patients, are almost invariably brought to services (general practitioner or psychiatrist) by family members, which may explain why rates of compulsion among them are not as high as for African-Caribbeans.[30] Other important and as yet under-researched areas such as ethnic differences in help seeking and explanatory models of illness may further explain higher detention rates in some ethnic minority groups.

Consequences of accusations of racism

These findings are quoted not to blame the victim but to highlight that there are perfectly reasonable alternative explanations for why the rates and manner of admission vary between different ethnic groups. Construing racism as the main explanation for the excess of detentions among ethnic minorities adds

little to the debate and prevents the search for the real causes of these differences. Alienation and distrust of the statutory services among inner city black youth is not restricted to the mental health services. In psychiatry, accusations of racism simply feed into ethnic minority communities' alienation and mistrust of services. They create a self fulfilling prophecy whereby ethnic minority patients are primed to expect services to be poor and racist, decline all offers of voluntary admission, are detained, and disengage with services over time.

Institutional racism would hardly be a credible explanation for the excess of diabetes in South Asians in Britain or hypertension in African-Caribbeans. Why do we accept it so readily in mental health? The blunt use of the term racism perpetuates conceptual confusion and inhibits the search for more credible explanations.[31] It also leads to a series of damaging consequences for the profession, ethnic minority groups, and, most crucially, for ethnic minority patients.

The claim of institutional racism damages the profession and patients. Firstly, such a vague, meaningless, yet insulting accusation contrasts with real attempts over the past 50 years to move away from mystifying jargon that cannot be interrogated. It devalues the thoughtful research that has been conducted to better understand these problems. It undermines morale and recruitment as staff feel undervalued and blamed. Secondly, it distracts both professionals and the minority communities from trying to understand these very real differences. Blaming others may bring temporary comfort but is hardly likely to lead to increased understanding and remedial action. Thirdly, and most gravely, it damages the welfare of current and potential ethnic minority patients. If they anticipate a racist and discriminatory reception from us then it is no surprise that they stay away from needed help until it is too late and there are few alternatives to detention and enforced treatment.

Getting beyond blame

Mental health practice has to build on trust. Trust can still be built even when there are real differences of perspective. If these painful but legitimate differences are simply dismissed as racism then there is little ground for such trust and understanding to grow. Racism is indeed prevalent in society. It is deeply damaging to individuals and certainly contributes to the problems of ethnic minority communities. There are real ethnic inequalities in mental health care, which deserve closer attention and remedial action. It is likely that racism, combined with economic disadvantage and social exclusion, contributes to poor experience of psychiatric services for minority communities. This should be explored in methodologically sound, hypothesis driven research, not simply accepted as the global explanation for all ethnic differences in mental illness and health care.

There are several fruitful avenues for understanding ethnic inequalities and thereby improving services for ethnic minority patients. Ethnicity is a complex multifaceted concept, but insufficient attention has been given to the most appropriate methods of classification of ethnic group.[32] More research is needed that distinguishes between different ethnic groups. Longitudinal studies that monitor the development of therapeutic relationships between ethnic minority patients and services over time should help identify factors that influence detention rates—such as engagement, access, and appropriateness of services. Future research should also look in depth at the process of application of the Mental Health Act. The true denominator for such studies is the population assessed for detention, not just the subgroup that is detained. The differential rate of detention may indeed be a function of lesser availability of alternatives to hospital treatment in certain ethnic groups. Data relating to both assessment and detention should therefore be routinely and centrally collected.

It is also vitally important that detention is not seen as a punitive measure. The Mental Health Act is an enabling act; it allows services to ensure that treatment is available for those most in need of it. The decision to detain an individual under the Mental Health Act involves a complex interaction between clinical judgment, the patient's psychopathology, risk, fulfilment of legal requirements, local availability of resources, and the patient's refusal to accept help on a voluntary basis. Simplistic explanations of racism as the only determinant of such complex processes simply reinforce prejudices without offering any solutions. There is a serious risk to potential patient care if charges of institutional racism deter staff from taking clinically appropriate decisions and actions. The factors that contribute to excess detention even in the first episode of mental illness must operate before presentation to mental health services. Hence, any potential solutions must go beyond the health sector and involve statutory as well as voluntary and community agencies. The problem does not reside exclusively in psychiatry and hence the solutions cannot emerge from psychiatric services alone.

Summary points

- The "Count me in" census for England and Wales showed higher rates of admission for mental illness and more adverse pathways to care for some black and minority ethnic groups and led to accusations of institutional racism within psychiatry
- This accusation of racism as an explanation for these findings is erroneous, misleading, and ultimately counterproductive
- It leads to several damaging consequences for the profession, ethnic minority groups, and, most crucially, for ethnic minority patients
- It acts like a self fulfilling prophecy by contributing to mistrust of services by ethnic minorities, thereby leading to delayed help seeking with increased use of detention and coercive treatments for ethnic minority patients

Contributors and sources: SPS trained as a psychiatrist in Chandigarh, India. For the past five years he has been running early

intervention in psychosis services in inner city multiethnic populations. TB was consultant for an inner city London community mental health team and an assertive community treatment team, both with multiethnic staff and patients, for over a decade.

Competing interests: SPS recently conducted a Department of Health funded review on ethnicity and detention under the Mental Health Act.

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Symptoms and semeions

In the Endpiece entitled "The name of the illness" (*BMJ* 2006;332:1070) Helen Worthington quoted Groopman as writing: "A doctor begins by examining the words of his patient to determine their clinical significance. He then translates the words into medical language."

This is precisely the process that Wilbush discussed when he wrote of the decline in the use of clinical information.[1] We are reared on symptoms and signs, but he described a third category of clinical information—the semeion: "Symptoms advertise illness … semeions are the evidentiary data discovered by the doctor when the patients is questioned."

The semeion is what we write down in our notes. But there is an unfortunate tendency these days to overlook the diagnostic value of the patient's own words and an exploration of them. Thus, the semeion is debased by substituting a jargon of convenience that serves to trigger investigation. As Wilbush put it, "few clinicians openly dispute the value of a medical history … many nonetheless appear to regard it as time-consuming and, in a world where time is money, obviously not cost effective."

A good example of this failing may be found in the management of tuberculosis. Haemoptysis is widely and necessarily publicised as a lead symptom of tuberculosis and must be investigated. But haemoptysis for that purpose is actually a semeion. Careful questioning of a symptom of "coughing up blood" may find that the patient was indeed coughing, had felt intense irritation of the pharynx, and coughed so forcefully that slight traces of bright red blood appeared on the handkerchief. Clinical records seldom show whether "haemoptysis" was symptom, semeion, or sign.

Ronald Ingle *retired general practitioner, South Africa* (inglerf@iafrica.com)

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. Please submit the article on http://submit.bmj.com Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.