

If racism exists in society, then surely it must influence mental health services

the bigger picture

Peter Ferns is an executive member of the Social Perspectives Network

1 Singh SP, Burns T. Race and mental health: there is more to race than racism. *British Medical Journal* 2006; 333: 648-651.

In September of 2006 Swaran P Singh, professor of social and community psychiatry at Warwick University, and Tom Burns, professor of social psychiatry at Oxford University, published a commentary in the *British Medical Journal*, in response to the most recent Healthcare Commission census of psychiatric inpatient admissions. Their argument was: 'There is more to race than racism', and that accusations of 'institutional racism' are not a useful response to the over-representation of people from black and minority ethnic groups in our psychiatric hospitals.¹

They wrote: 'Simplistic explanations of racism as the only determinant of such complex processes simply reinforce prejudices without offering any solutions.' Moreover: '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 [...] Secondly, it distracts both professionals and the minority communities from trying to understand these very real differences [...] 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.'

Their overall analysis would suggest that we should not waste our energy and resources on training mental health practitioners about racism and discrimination but instead focus on understanding 'cultural differences' among ethnic groups and why they do not seek help from services. In other words, we should take 'simplistic explanations of racism' and the imbalances of power between practitioners and service users and carers out of the equation when considering black and minority ethnic (BME) mental health.

There are several key problems with such an analysis.

If racism exists in society, then surely it must influence mental health services, and if this is the case it is an important factor in the experiences of BME people using those services, and must be taken into account if an accurate analysis of BME service user experience is to be made.

Furthermore, if we continue to wait for incontrovertible scientific proof that institutional racism exists we will continue to ignore the real plight of BME

people currently in the mental health system. We do not need scientific proof to know when to do the right thing. We can use ethical and moral judgements based on wider social, political and economic considerations as well as scientific proof, which can have hidden biases.

Very few people would suggest that racism is 'the only determinant' that leads to the compulsory detention of BME people. Indeed there are many complex factors that contribute to such a consequence. However, an analysis of institutional racism does offer a more accurate view of the real situation for BME people and enables better clinical judgements to be made that can lead to different anti-discriminatory and culturally appropriate interventions.

Having high profile examples of poor treatment of BME people will have a much bigger impact on the perceptions of BME communities than any research paper, academic debate or conference speech. People are influenced by their personal experiences or the experiences of others in their communities and there are too many negative ones in relation to BME people in mental health services. The only way those perceptions are going to be changed is by a genuine and demonstrable improvement in services to BME people, not by denying the problem. Worse still is to blame BME people for having negative expectations of mental health services when the evidence suggests that this is not unreasonable.

Denying an unpleasant reality will not alter it, and encouraging practitioners not to accept criticisms about racism plays into the hands of people who are unwilling to take accountability for their personal practice. It merely leads to apathy and inaction. There is a larger group of practitioners who feel powerless in the face of institutional racism but it is important to give a positive message that individual practitioners can make a difference to BME service users. The importance of human relationships in mental health work is still one of the most powerful factors in a person's recovery whether service users and practitioners are black or white.

There is a way forward and further research must focus on how we can improve the quality of services for BME people. But without a careful and accurate analysis of institutional racism and an active approach to promoting race equality we will continue to have poor professional judgements being made of BME people in mental distress and poor outcomes for this group. ■