

Psychiatry, race and culture



A challenge for the mental
health professions

MindThink report 4



For better
mental health

Acknowledgement

'Psychiatry, race and culture' was supported by Delivering Race Equality in Mental Health Care.

"The Delivering Race Equality in Mental Health Care programme (DRE) aims to inform and influence the delivery of improved services to people from black and minority ethnic communities. As part of that process, we welcome and support a climate of informed debate and discussion among mental health professionals, service users and carers and the voluntary and community sectors. We believe that through dialogue comes greater understanding and change."

Participants

Marcel Vige (Diverse Minds Manager); Cashain David (seminar chair); Rampaul Chamba (service user, researcher); Dr Shubilade Smith (psychiatrist, South London and Maudsley NHS Foundation Trust); Sandra Griffiths (Programme Coordinator, Mellow); Peter Scott-Blackman (Director, Afiya Trust); Dr Frank Keating (academic); Professor Suman Fernando (retired psychiatrist and academic); Jim Fowles (Programme Lead, Department of Health).

Introduction

MindThink seminars focus on the future direction of policy, on the fundamental questions and assumptions that lie at the heart of our thinking about mental health, and on critical scrutiny of attitudes and assumptions that are often taken for granted. Each event brings together service users, professionals, policy experts and advisers, academics, journalists and other opinion-makers to discuss a key issue.

The aim of our MindThink work is to promote debate, not pre-empt it; to provide creative space for progressive policy ideas to flourish, not to arrive at a list of definitive policy prescriptions; to allow people to speak freely and to exchange ideas, not to have the last word.

The MindThink seminar held on 7 December 2007 at Kings Fund in London explored the relationship between the psychiatric profession and ethnic differences in the experience of mental health services. The seminar brought together stakeholders ranging from service users, psychiatrists, voluntary sector representatives, academics and campaigners, all with expertise in race and mental health. Mind is grateful for the support for the seminar provided by the Delivering Race Equality in Mental Health programme.

“The biomedical basis of psychiatry claimed by the profession fosters the illusion of a ‘culture-blind’ science. In truth, psychiatry is as much a cultural expression as other socially and historically rooted institutions. It is constructed within a cultural/political framework. Evaluating the normality/abnormality of behaviour is inevitably a culturally determined act, influenced by mores – including ethnic discrimination – present in wider society. It could be argued that adherence to the biomedical approach prevents full realisation of this within the profession. Psychiatry is therefore ill equipped to deal with the implications of its own cultural position. It is on this basis that psychiatry has been described as institutionally racist. Though individual practitioners may attempt to mediate their practice according to the ethnic or cultural reality of their patients, in general, the profession follows its own cultural norms.”

MindThink speaker

“Over recent years there has been increased awareness and acknowledgement of racism within psychiatry. Over the period there seems to be a prevailing view that things have not changed. Actually, there are now more Asian, African and African-Caribbean psychiatrists in London hospitals. This is also the case (though to a lesser degree) across the country. Sometimes it is the case that there are more black psychiatric staff than patients. Psychiatry is no more or less racist than the rest of the world. We should be building on the strategies to develop psychiatry.”

MindThink speaker

“All patients, on all wards, have difficult backgrounds. This is what binds them, not ethnicity per se. Racism expresses itself in the lower expectations of BME patients – black men in particular – held by psychiatric staff. That said, such racialised differences in expectations are not specific to psychiatry.”

MindThink speaker

Why this issue?

There is a sizable body of evidence detailing the over-representation and disproportionately negative experiences of BME people within secure mental health settings. Understanding and responding to the causes of this have over many years generated heated debate among service users, academics, community representatives and others. The issue has therefore become highly politicised and contentious. Although there is general acceptance that the drivers of ethnic disparity are multifaceted, debates tend to focus on the relative influence of a range of factors (poverty, cultural taboos, the bias of some mental health professionals) which both directly and indirectly impact on mental health practice. The purpose of this seminar was to explore the role of psychiatry in perpetuating this disparity.

A specific question was how institutional racism¹ manifests within mental health professions, in particular psychiatry. Exploring this question is timely given the concerns raised by many across both voluntary and statutory sectors about the recently amended Mental Health Act and its potentially adverse ramifications for people from BME communities – African-Caribbean people in particular. In addition, there are well established differences of opinion among academics and professionals who engage with the interaction of notions of race or ethnicity and mental health. Views range from viewing racial bias as an inevitable consequence of psychiatric practice, to understanding psychiatry as simply receiving the products of broader social forces (and possibly biological factors), which lead to increased incidence of mental illness among particular ethnic and cultural groups.

During the seminar, contributors invoked the origins and development of psychiatry, referring to notions of normality and abnormality and how these are loaded with racial and cultural significance. From this position, psychiatry is

1. “Institutional racism is that which, covertly or overtly, resides in the policies, procedures, operations and culture of public or private institutions – reinforcing individual prejudices and being reinforced by them in turn. Whereas individual racism is the expression of personal prejudice, institutional racism is the expression of a whole organisation’s racist practice and culture.” (Institute of Race Relations: www.irr.org.uk/statistics/institutional.html)

perceived as a form of 'conceptual imperialism', holding westernised notions of 'right thinking' and behaviour (wellness) as the norm, deviation from which represents abnormality (illness). Alternatively, others argued that mental health practitioners are not bound by such histories. While there may be instances of discriminatory practice, psychiatry as a profession is essentially neutral. From this position, psychiatrists and associated professionals are sufficiently skilled and sensitive to make appropriate therapeutic decisions in the best interests of their patients. Differences in sectioning rates therefore reflect the ethnic profile of those who come to the attention of psychiatric services.

“With criticisms levied at psychiatry, and the resultant drive to broaden its conceptual base away from the biomedical, social factors take on greater explanatory significance. There is a danger that we go too far with this approach, dispensing with biomedical explanations entirely.”

Despite these substantial differences of view, there was general agreement that the issues cannot be distilled into simplistic, one-dimensional explanations. Debates focused on the degree to which different factors determine interactions within services. This is also critical in determining appropriate responses to improve the relationship between BME people and mental health professions.

Psychiatry – its nature and operation

Despite the ascendancy of self-directed support and a greater willingness to challenge professional knowledge and practice, psychiatry still retains a unique authority to determine what is and is not deemed 'right thinking', feeling and behaving. This authority is largely based on the coming together of biomedical (objective/empirical) and psychosocial (subjective/implicit) domains, such that psychiatry represents the application of scientific/medical disciplines to the behaviour of people. Contributors to this first part of the seminar discussed some of the implications of this in relation to ethnic disparity within the mental health system. Though there was agreement that the cultural reality of wider society influences psychiatric knowledge and practice, there was debate over the value of identifying the profession as institutionally racist. This highlighted differing views on the extent to which racism within psychiatry is a 'carry-over' of racism present in wider society, or whether by its very nature psychiatry is predisposed to ethnic discrimination.

The wider context

Despite the apparent consensus that ethnic bias is in some way a product of psychiatry, contributors clearly had differing views on how far things had improved. This raised further questions regarding the extent to which ethnic bias is part of a broader complex of issues – including challenging life-histories and general stigma, which determine the experience of most service users. Contributors agreed that low expectations of BME service-users by mental health staff are both a consequence and reinforcer of racial bias.

Social factors

There is increasing acceptance that the biomedical model is inadequate in accounting for the differences in mental health indicators across ethnic groups. Despite this, there are still challenges in combining the social narrative of service users and the diagnostic narrative of psychiatry. Such challenges reflect basic power differences between professionals and recipients of psychiatric intervention. There are also issues around skills and resources for mental health

The following quotations are taken from the group discussion emerging from individual attendee presentations on their position on psychiatry. In keeping with the constructive focus of the seminar, comments were geared towards identifying solutions.

“Ethnic matching (matching is the process of pairing black service users to black staff) has been proposed as a way of changing things. A positive idea, but not without broader changes within services which enable the effects of ethnic matching to be realised.”

“Increase in black staff may be because many do not want to work on wards [a sort of ‘white flight’]. Psychiatry is seen amongst medical students as an unattractive profession.”

“There is often an assumption that ‘African’ and ‘African-Caribbean’ are synonymous. There are often inter-assumptions and prejudice within BME groups.”

“Psychiatry is ill-equipped to deal with social ills. It’s not a reasonable expectation to expect the profession to do so.”

“The system should be picking up and addressing these conflicts. Psychiatry is not taking positive steps to remedy this situation. It should not just reflect what’s in society. The fact that it does so is not part of the medical tradition.”

staff – how equipped are staff to engage more holistically with service users? This raises questions about the quality of multidisciplinary working across mental health, social care and other support agencies. Though the Care Programme Approach (CPA – system of co-ordinating care across all agencies involved) should address these issues, according to contributors, it tends not to do so in practice.

One speaker questioned whether it is appropriate for mental health services to draw more heavily from a social approach: “With criticisms levied at psychiatry, and the resultant drive to broaden its conceptual base away from the biomedical, social factors take on greater explanatory significance. There is a danger that we go too far with this approach, dispensing with biomedical explanations entirely. This is simply a reproduction of a one-dimensional approach for which psychiatry is now criticised. This also raises questions about what constitutes legitimate forms of knowledge.”

The position expressed by the above speaker is that psychiatry is not entirely culturally determined – ‘legitimate’ psychiatry rests on ‘objective science’. The issue therefore becomes the practice of psychiatry. Rather than referring to the underlying precepts that are the basis of psychiatry, the focus shifts on to the quality of provision, whether or not provision is built around the needs of the service user. Accordingly, a thorough analysis and subsequent reorganisation of the provision would be sufficient to redress the balance. This is the thinking behind policies such as Delivering Race Equality, which seek to mitigate the worst excesses of ethnic discrimination within mental health settings. We now turn to how this might work.

As part of the statutory requirement to develop and adhere to a race equality scheme, a health trust may commission a Race Equality Impact Assessment of its mental health services. This might reveal that the time allotted for patient consultations limits full disclosure by those who used translators to communicate. It might also reveal unique modes of communication and understanding of mental health issues. The challenge for the service would be to adjust aspects of the environment, organisation of services, training of staff to mitigate against each problem

as it is identified. Ultimately, this should lead to a service built around the needs of service users.

Clearly, this represents a less radical position that does not question the fundamentals of psychiatry as a discipline. This is perhaps more realistic given that it seeks to develop (rather than sweep away) established modes of responding to mental health issues. Assuming that psychiatry encounters the consequences of ethnic disparity within wider society, there is even potential to raise the stakes and develop psychiatry into a form which directly engages with such issues. This is about psychiatry purposefully integrating issues of race, ethnicity and culture rather than responding after such issues have been identified, based on inadequacies revealed about the quality of services. There are numerous psychiatrists up and down the country who are already integrating ethnicity into the therapeutic process.

Legitimacy of evidence and experience as evidence

Here the group reflected on the various drivers of research – how the development of evidence is a value-driven enterprise. Speakers pointed out that there is bias in terms of frameworks through which pathology is understood. There is also bias in terms of who funds research or sits on funding bodies. This impacts on what is construed as ‘legitimate’ evidence.

“The inherent bias in understanding is so profound, deep-seated and normalised that it does not enter our consciousness. We tend not to question evidence on such terms. This is an example of a more pervasive cultural dynamic that locates the ‘other’ outside of what is deemed legitimate, appropriate and ‘normal’. An example is acknowledgement, even reverence, of various cultural deities and cosmologies, while such cultural expressions emerging from traditional African cultures are at best still seen as primitive and quaint. It’s important to understand that this is the context in which ‘mainstream’ knowledge is formed.”

Final reflections

Participants (those present and those unable to attend) were asked to respond to the following question:

“People from black communities generally have a worse experience of the mental health system than their white counterparts. According to current forms of diagnosis, people from particular ethnic groups also have poorer mental health indicators. If this situation is to be comprehensively addressed, what does this mean for psychiatry?”

The following are extracts of some of the responses (statements attributed):

“I think first and foremost, we need systemic change because the inequalities and disparities that people from black communities experience in mental health services are deeply influenced by how these services operate and are organised. This is based on the view that institutional racism requires institutional reform. This of course needs to go hand in hand with changing individual practice, because this is where inequality is most manifest.

“Services need to adopt a rights-based approach to providing mental health care and support. This means promoting black people’s rights to equality and equity, promoting their representation at all levels of service delivery, and building a culture of respect and tolerance for diversity. We also need to support the development of a much stronger service user movement and voice.

“Finally, I would argue that mental health services cannot ‘go it alone’ – a multi-agency and multidisciplinary approach is needed to reduce and eradicate racial disparities in mental health services.”

Dr Frank Keating

“Some years ago, the psychiatrist Bernard Ineichen, argued that the controversy about black people and mental health services had become more complicated than it should be because of the confusion between, and entanglement of, two different issues.

“One issue was black people’s experiences of mental health services and pathways to care... research had shown that black people’s experiences showed their dissatisfaction with services due to racism and ‘one-size-fits-all services’ approach to service delivery...

“The second issue was whether black people, specifically, African-Caribbeans were actually more susceptible to schizophrenia and therefore accounted for the higher rates of diagnoses among this group.

“For Ineichen, while these two strands were not mutually exclusive – because racism could play a role in both domains – they were not exactly the same either. There may be something to be gained from these points.”

Rampaul Chamba
Service user/Researcher

“In relation to black and other ethnic minority groups in the UK, for example, conventional epidemiological and clinical studies repeatedly point to the discriminatory nature of the psychiatric care received by them. The increased risk of coercive psychiatric interventions in the pathway into psychiatric care, the discrepancies between ethnic groups in assessment and identification of needs and risks, the nature and location of psychiatric treatment and differential outcome have all been identified time and again in such studies and, furthermore, these issues continue to be the subject of a number of local and national enquiries and reports.

“The testimony of black patients and carers and the perceptions of the black communities also appear to be consistent

with this general theme that there is no aspect of contemporary psychiatric care that favours black people when compared to white patients and, in overall terms, psychiatry, like policing, the criminal justice system, educational institutions and social work, militates against the interests of black people in this country. The argument is no longer about over- or under-representation of black people and other ethnic minority groups within psychiatry, but how such communities experience psychiatry and why such experience is largely negative and discriminatory in nature.”

Waheed Chaker (NLP Practitioner)

“There is little credence to the argument that what happens to black people within mental health services is simply a product of individual racism or, a consequence of cultural ignorance on the part of practitioners. The roots of racism within psychiatric care can be traced to the conceptual and theoretical framework of what constitutes modern psychiatry. The nature of psychiatric practices and procedures arising from knowledge-base as well as professionally sanctioned activities around social control has become fundamental to what constitutes mental health activities.”

“In many ways it would be possible to challenge and even correct such discrepant and discriminatory practices by setting targets for providers and creating alternative and community-based services – assuming that there is political will and professional commitment, both of which are lacking. A far bigger challenge will be to address the cultural and historical specificity of psychiatry, in particular the theoretical underpinning of diagnosis and classification.”

Delroy Constantine-Simms
Occupational Psychologist and Psychometrician
Think Doctor Psychological Assessments and Associates

The next steps

Despite the differences of view expressed in this seminar, the debate itself is an indication of the developments in psychiatry and the related professions over the past 30 years or so. This period has seen an increasing willingness to engage in discussions over the nature of psychiatric practice, the nature of mental illness and the extent to which such notions are themselves cultural expressions.

Such reflections are part of a broader philosophical shift towards a postmodern, poststructuralist understanding of the world, reflected in academic circles; in particular the social sciences. This coincides with a host of social movements such as civil rights, the women's movement, the break-up of the Soviet Union and the spread of globalisation – all of which feed into a general erosion of established edifices such as the inalienable 'truth' of professional knowledge.

From this position, psychiatry is revealed as a set of precepts and practices which serve to maintain particular definitions of, and responses to, 'mental illness' in keeping with a particular cultural expression loosely defined as 'western'. This is the basis on which critiques of psychiatry gain legitimacy.

If all knowledge is culturally located, the obvious question arises whose interests are/aren't served by construing particular forms of knowledge as legitimate and truthful. Issues of mental health in relation to BME people confront the profession with questions of how to respond to those who come from a different cultural base. These questions confront psychiatry with its own cultural relativity, the implications of which have been the focus of this seminar.

Psychiatry and the related mental health profession are at a crossroads. Given the difficult questions to which it must now respond, the choices are either to undergo a drastic reconfiguration, which aligns the profession with a new social-cultural content where practice is both robust and broad enough to respond a diversity of needs, or to become an increasingly archaic, outmoded discipline, retaining an approach to people and their problems divorced from people's sense of themselves. There are signs that the profession is grappling with these issues, most notably the fact that the points raised in this report will not be new to most within the profession. However, what this means for psychiatric practice and the future of the profession remains to be seen.

Mind
15–19 Broadway
London E15 4BQ
T: 020 8519 2122
F: 020 8522 1725
w: www.mind.org.uk

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