the columns

correspondence

Institutional racism in psychiatry

The debate on the causes of disparities in mental healthcare and outcome in different ethnic groups is complex. The consensus is that there are many reasons for the disparities, including ethnic variations in illness models, the perceived attractiveness of services and access to services. Attention to choice, workforce development and service redesign can improve access to and take up of care by under-served groups, improve cultural capability and so decrease disparities. To believe that disparities in care and outcome are not at least in part a reflection of our institutions would defy reason.

There are many examples of institutions making choices which affect quality of care (for example, the underfunding of interpreting services which mean that some Black and minority ethnic groups do not get equitable care). Some choices are more obscurely related to poor outcomes (for example, services not recruiting community development workers; McKenzie & Bhui, 2007). In all other public services, choices or service configurations which inadvertently lead to disparities for Black or minority ethnic groups are called institutional or structural racism.

It is not scientific to pretend racism does not exist in its individual or structural forms, or to suggest that racism is something health professionals should not consider and manage. A well-informed research programme on this topic could benefit public mental health (McKenzie, 2003).

Racism and institutional racism are key variables that are as relevant as other socioeconomic factors. In particular, there is an accumulation of evidence that perceived discrimination and racism are linked to poorer mental health outcomes (Karlsen & Nazroo, 2002; Nazroo, 2003; Bhui *et al*, 2005; Harris *et al*, 2006; Paradies, 2006; Veling *et al*, 2007). Nowhere in such debates has anyone proffered racism as the only cause of disparities and ignored all other sociocultural variables.

It is clear that this subject is challenging and such problems need to be constructively and honestly negotiated by clinicians, service providers, healthcare regulators and policy makers – not least because these concepts are enshrined in law, and services have a duty to deliver race equality and promote good race relations. However, it is another matter to deny that institutional/structural racism is a problem in public services, or perhaps to favour a more convenient form of language that obscures the objective and makes moving forward more difficult. With the weight of evidence that there is on this subject (for a review see Sashidharan, 2003) and the consensus of experts, service users, communities and the voluntary sector, ignoring individual and structural racism as a daily social reality and as a factor in human suffering and poor mental health would be neither scientific, constructive or humane.

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We are surprised that Professors Singh and Murray and Dr Fearon (pp. 363–366, this issue) refuse to engage with the concept of institutional discrimination. We agree that institutional racism is not something that can be tested empirically or investigated readily using the standards of positivist scientific proof. It is therefore not unsurprising that we do not have the kind of 'evidence' that Professor Singh calls for. However, the lack of previous research should be a call to action, not a reason to ignore the issue.

We know that many Black people who have received mental healthcare perceive discrimination in services (Sainsbury Centre for Mental Health, 2002; Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003; Mental Health Act Commission, 2006). A sociological framework is required to understand better the way in which this occurs. Without an acceptance that there are differing ways of knowing and understanding the world, further dialogue is limited by emotional and anxious fears.

Using a wider 'sociological lens' allows us to appreciate the ways in which particular approaches to knowledge are used to sustain race-neutral conceptions of certain fields of endeavour and suppress the experience of other voices (Nkomo, 1992). The logical conclusion from Singh, Murray and Fearon's argument would be the adoption of a colour-blind approach to mental health service provision. Yet it is exactly this kind of approach that has resulted in the faulty premise that because institutional racism has not been assessed in a randomised control trial it does not exist. There should indeed be more research on institutional racism as it

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is a largely neglected issue in the field of organisational studies.

Solomos (1999) criticises the definition of institutional racism given by MacPherson and cautions against 'using such terminology . . . loosely and rhetorically'. The discourse must be given a context within the particular setting being considered, as only then can we begin to understand how the discourse itself determines our conceptions about race or ethnicity.

We do agree with McKenzie & Bhui that it is important to focus on the needs of patients. Notwithstanding our concern that institutional discrimination may be one factor in the over-representation of Black groups in mental health services, we believe that much more must be done to tackle the problem. The disproportionate admission and detention rates for Black groups, especially (young) Black British men and women, suggests either serious problems with public services (including mental health services) or an epidemic of mental illness in these groups. Whichever it is, whether it is a mixture of factors, it demands urgent attention, with the recognition that this is not solely a health service issue but requires concerted cross-government action.

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The central point of Professor Singh's piece (pp. 363–365, this issue) is that neither institutional nor individual-level racism accounts for the high rates of serious mental illness among African–Caribbean and African people living in England. Patel & Heginbotham (pp. 367–368, this issue) claim that 'all the evidence suggests that Black people and many people from other minority ethnic groups are being admitted to and detained in psychiatric hospitals either unnecessarily or at disproportionate rates'. There is absolutely no evidence for the former and scant evidence for the latter. Rather, as with alcoholism in Scottish and Irish, and coronary artery disease in Asian people living in England, the raised admission rates among Black people in England are a proportionate response to high rates of illness onset. Research shows that it is the circumstances in which Black people live in England that account for the vast bulk of the excess of illness. Attributing the high rates to racism (institutional or otherwise) in the psychiatric services does a disservice to ill Black people and their families who are in immediate need of skilled help. It also prevents a focus on the real culprits, which are discrimination and isolation in society, unemployment, insufficient support for poor families and single mothers, and being brought up in inner cities where crime and drug misuse are rife. Until exposure to these risk factors is diminished, people of African–Caribbean, and to a lesser extent African origin will continue to become ill at rates considerably above those of both the native White population and other minority groups living in England. As Professor McKenzie wrote in the *Guardian* recently (2 April 2007) when discussing the high rates of serious mental illness in Black British people: 'If we knew that one group in society were 10 times more likely to develop lung cancer, we would focus on them – perhaps with a targeted anti-smoking strategy. We would not just make lung cancer treatment services more equitable.'

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Using the media as an educational tool

Many people from the South-Asian community do not have English as their primary language. First-generation South-Asians have high rates of illiteracy, and health information may be better communicated by television and radio programmes in their native language. Health information in a variety of languages in written form is becoming more accessible, but is not useful for those who cannot access it because of literacy difficulties.

Recently an opportunity arose to discuss issues related to mental health on a local Asian radio station in Nottingham and an Asian channel on satellite television. I found it a valuable learning experience and was encouraged by the positive feedback from the public. Speaking in the Kashmiri language to a predominantly Pakistani audience allowed participation of members of our communities who are often reluctant or unable to share their views and concerns on mental health matters.

I would encourage my psychiatry colleagues to take any opportunities that may arise to utilise their language skills in the mental health education of the general public using the local, national or even international media.

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Psychotherapy competencies in trainees in South Wales

A survey of psychiatric trainees was conducted in South Wales based on suggested educational experiences/competencies set by the Psychotherapy Specialist Advisory SubCommittee of the Royal College of Psychiatrists' Specialist Training Committee for trainees not undergoing specialist psychotherapy training.

Out of 88 trainees applying for ST2 and ST3 from all five training schemes in South Wales, 40 returned completed questionnaires. None of the surveyed trainees had all the competencies required to apply for their respective ST grade at the time the survey was conducted. Numbers of trainees achieving the suggested educational experiences/competencies were as follows: case presentations in Balint groups, $n=5$; extended psychotherapy case, $n=1$; briefer psychology interventions, $n=2$; paper presentations on psychological treatments, $n=3$; attendance at psychotherapy unit business meeting, $n=3$; patient assessments for psychological treatment with trainer, $n=8$; didactic input for assessment of patients for psychological treatment, $n=11$.

Trainees from resource-poor regions are disadvantaged when applying in open competition with trainees from regions blessed with better infrastructure and training facilities. It seems unfair to expect trainees to demonstrate competencies for which they have not been provided the educational supervision or opportunity to develop. From a trainee's perspective, it would have been better if the list of competencies had been finalised and circulated earlier, giving trainees more time to achieve them. It would also have helped the trainees if competencies could have been drawn up to reflect achievable standards across the entire UK and not just standards achievable in a

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