the columns

correspondence

Institutional racism in British psychiatry?

The president of the College was recently reported (*BMA News*, 28 September 2002) to have expressed the opinion that there is an element of institutional racism in (presumably British) psychiatry. He gave as evidence of this: 'You are six times as likely to be sectioned [sic] under the 1983 Mental Health Act if you are black, young and male.'

No doubt some psychiatrists hold racist attitudes, as do many other people. However, the president's suggestion that psychiatrists in this country allow any racial views they may privately hold to influence their professsional practice is unjustified and offensive. His view that the fact, if it be one, that young black males are admitted to hospital under the provisions of the Mental Health Act 1983 more frequently than are others, is evidence of improper practice, based on racial attitudes, is self-evidently absurd. That the president of a medical royal college should hold such an opinion must be a matter for concern.

I would suggest that a retraction of the reported remarks, accompanied by an apology on the part of the president to the College membership, would be appropriate.

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Reply to Ian Bronks' letter for the *Bulletin*: Mike Shooter

First things first, I did indeed talk about the possibility of institutional racism in both the practice of psychiatry and the structures of our psychiatric profession (the two may not be unconnected). I did so as part of a speech to the inaugural meeting of the British Association of Pakistani Psychiatrists in Birmingham about the challenges facing the College in the next few years.

Institutional racism was defined in the MacPherson Report as 'The collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which amount to discrimination, through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people'.

The key words here, I think, are 'collective', 'service' and 'unthinking'. By this definition, I believe that the implementation of any legislation that results in young black males who live in inner city areas being six times more likely to be caught by it, must contain an element of institutional racism – and one can see why.

Young black males tell us that they are wary of psychiatric services that do not seem sympathetic to them; they feel, with some justification, that they are more likely to be perceived as dangerous than their white counterparts. They are loath, therefore, to come forward early when treatment might be most effective and the consequences complete the vicious circle. I think that is a collective failure that we all need to address, including a government whose current proposals for Mental Health Act reform would compound the problem with their emphasis on dangerousness and their loose criteria for compulsion.

I make no apology for this view, or for the fact that the College has commissioned a three-year external audit of all its processes and structures for evidence of institutional racism. I am not sure that we can expect to eradicate it from practice if it is there in the College to which we belong – unwitting though that may be.

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Assertive community treatment

We are grateful to T. Burns and J Catty for calling attention to the importance of 'Defining the comparator and identifying active ingredients' of the conditions being studied (*Psychiatric Bulletin*, September 2002, **26**, 324–327). We agree on the importance of the accurate use of the terms used to describe treatment models when making comparisons. We applaud their call to be more rigorous in this regard and want to point out an example of how difficult this seems to be. In their paper, they assert that the impressive advantages of assertive community treatment (ACT) reported in earlier studies are not being repeated in later studies. To support their assertion, they then reference two UK studies (Thornicroft *et al*, 1998; UK 700 group, 1999). Unfortunately neither of these are studies of ACT.

This error is particularly egregious because it has been pointed out previously in the literature that these are not studies of ACT (Marshall *et al*, 2000; Rosen & Teesson, 2001). It is clearly misleading to label these as ACT studies, and yet they continue to perpetuate this misrepresentation. By mis-labelling studies as ACT, even though clear criteria have been developed to identify and measure ACT's essential elements (Teague *et al*, 1998), the authors demonstrate that it is difficult for them to practise what they so rightly preach. As they point out, these kinds of errors cloud rather than clarify our understanding of the role various models could play in a system of care.

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TEAGUE, G. B., BOND, G. R. & DRAKE, R. E. (1998) Program fidelity in assertive community treatment. *American Journal of Orthopsychiatry*, **68**, 216–232.

THORNICROFT, G., WYKES, T., HOLLOWAY, F., *et al* (1998) From efficacy to effectiveness in community mental health services. PRiSM psychosis study, 10. *British Journal of Psychiatry*, **173**, 423–427.

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We are delighted that our work is read by such influential figures in the ACT world and that they appreciate our attempt to bring scientific rigour to

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