

## Editorial

# Clinical ethnography in severe mental illness: a clinical method to tackle social determinants and structural racism in personalised care

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Ethnic inequalities in the experiences and outcomes of severe mental illness are well established. These include a higher incidence of severe mental illnesses (psychoses), adverse pathways into and through care, including crisis care, police and criminal justice systems involvement, and care under the powers of the Mental Health Act. The situation persists despite awareness and is driven by a mixture of the social determinants of poor health, societal disadvantage and structural racism, as well as conflictual interactions with care systems, which themselves are configured in ways that sustain or deepen these inequalities. Although training and education are often proposed, this is not shown to have sustained effects. Clinical processes (interviewing/assessment/formulation/intervention) need to address systemic influences and improve the cultural precision with which care is delivered, organised and commissioned. We discuss clinical ethnography and present evidence of its value in

addressing systemic as well as individual care needs for diverse communities.

## Keywords

Ethnicity; severe mental illness; racism; ethnography; inequalities.

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## Ethnic inequalities of severe mental illness

Ethnic inequalities in experiences and outcomes of severe mental illness have been demonstrated for several decades, including a higher incidence of psychosis-related service contacts (Black Caribbean, Black African, South Asian, mixed heritage and migrants) and poorer mental and physical health outcomes related to racism.<sup>1–3</sup> Personality disorder diagnoses are less common in Black patients in routine clinical practice, but there is less ethnic difference if more reliable structured assessments are used.<sup>4</sup> Black Caribbean, Black African, South Asian (Indian, Pakistani, Bangladeshi), migrants and minoritised/racialised groups in general experience adverse pathways to care, including more crisis care delivered in emergency departments, and the police and criminal justice system, more care under the powers of the Mental Health Act, less access to effective psychotherapies and more pharmacological interventions.<sup>5,6</sup> These inequalities may be considered inevitable consequences of the communication challenges across linguistic and cultural barriers but can be better understood as expressions of structural or institutional racism.

Racism is one of the many social determinants of poor health, but there is little action to surface direct and indirect consequences of racism, nor are there interventions to engage with patients' narratives of racism. Racism influences the lens through which people's

abilities and hopes are seen and acted upon when minoritised groups engage with public services including housing, education, employment and welfare support, all of which may lead to more need for healthcare. If minoritised groups seek help for mental distress linked closely to social stressors (such as poor housing or poverty), their access to care may be hindered by the constraints those stressors place on their ability to seek help, engage with and use interventions. These social stressors are frequently set aside by practitioners and disconnected from healthcare and services in ways that prevent meaningful advocacy and social support during crises and periods of help-seeking.

If healthcare solutions proffered are themselves produced by practices that are blind to racism and also generate and perpetuate inequalities, patients may fear and avoid health services. Thus, clinical practice needs to incorporate assessment and intervention directed towards social determinants and structural racism. Expectations of care and health beliefs are one modifiable cause of conflict, relationship breakdowns and disengagement.<sup>7</sup> Addressing health beliefs may avert frustration and conflict within therapeutic relationships<sup>8</sup> and support treatment effectiveness. Some ethnically minoritised people consult traditional and religious healers who share spiritual models of mental distress and offer culturally congruent forms of help, but this process may delay access to formal health services.<sup>9</sup> Furthermore, traditional and religious healers may help with depression and anxiety symptoms, but there is no evidence of benefits for people with bipolar disorder or psychosis.<sup>10</sup>

Up to 40% of people with severe mental illness, in need of ongoing care, disengage from community mental health services. Men, young people, some ethnic groups and people facing isolation, marginalisation and deprivation have higher rates of disengagement from mental health services.<sup>11,12</sup> Those who disengage experience delays in receipt of effective care, and this may lead to no care, or more restrictive treatments if there is a subsequent crisis (including involuntary admissions) at a greater cost to the National Health Service (NHS). There are also additional risks of suicide and

violence related to untreated mental illness, and attendant criminal justice system involvement. Dangerous stereotypes of Black patients may perpetuate coercive care and over-restrictive practices that are in themselves dangerous, extending concerns about the safety of services.<sup>13</sup>

How should practitioners and service providers, not to mention commissioners and policymakers respond? There are many public health, and early preventive actions that can be taken to protect people from adverse experiences and to challenge discrimination. Yet, clinicians encountering patients with complex problems lack meaningful and practical approaches that consider wider systemic harms, such as racism, and improve practice and outcomes. A systematic review of therapeutic communications in ethnically minoritised populations demonstrated the importance of ethnography, among the many approaches that seek to improve cultural competence, capability and the effectiveness of healthcare interventions.<sup>14</sup>

### Ethnography as a clinical and systemic intervention

Ethnographic research methods are used in social science to gather knowledge that attends to narratives (or stories) and beliefs. In this paper we use the term clinical ethnography and highlight the use of ethnographic methods in clinical interviewing and care delivery

Dominicé Dao et al<sup>15</sup> define clinical ethnography thus: ‘... encourages clinicians to explore the patient’s explanatory model of illness, recourse to traditional and alternative healing practices, healthcare expectations and social context, and to use this information to negotiate a mutually acceptable treatment plan’.

Calabrese’s definition<sup>16</sup> expands on this: ‘... culturally- and clinically-informed self-reflective immersion in local worlds of suffering, healing, and wellbeing to produce data that is of clinical as well as anthropological value’.

Ethnography in research may use participant observations, informal conversations, semi-structured interviews and the collection of visual data such as photographs and recordings to reveal a person’s narratives, perspectives, values and the way people organise their experiences to create meaning and coherence, taking account of family, and cultural and religious norms. Ethnographic methods have also been used to study clinical practice and health systems, notably in rapid ethnographies that seek to improve understanding of care needs, improve services, and inform policy and commissioning.<sup>17,18</sup>

Clinical ethnography harnesses the ethnographic practice of interviewing and uncovering subjective meaning and relocates this in clinical endeavours to enhance the clinician’s understanding of the patient’s world view, and their ‘emic’ or insider perspectives. This can include gathering knowledge about cultural heritage, health beliefs and biographies, to inform adaptation of care practices for immigrants, minoritised and indigenous people. The objective is to use this deeper understanding to improve the care offered, adapting it as needed, to the context of the patient.

The proposed method of clinical enquiry is empowering with beneficial outcomes in a diverse range of conditions and patient populations.<sup>14,19,20</sup> The theory of change differs from behaviour change interventions that rely on cognitions, for example the health belief model, theories of reasoned action, planned behaviour and transtheoretical models by taking much greater account of the wider systemic social, economic and cultural constraints.<sup>21,22</sup> In contrast, clinical ethnography considers systemic factors that influence onset and recovery from mental illness, given its roots in social anthropology and attention to kinship, economics and cultural knowledge, actions and behaviours.<sup>8,19</sup>

Clinical ethnography also encourages power sharing and gives prominence to the patient’s voice in the consultation, engendering

trust, motivating help-seeking, and improving the quality of care, engagement and outcomes for culturally diverse patients in mental health services.<sup>8,20,23–26</sup> Non-randomised studies show the approach leads to better diagnosis and treatment, improved outcomes in psychosis,<sup>8,14</sup> as well as uptake of, and better outcomes in psychotherapy for depression.<sup>25</sup> In previous work, we successfully adapted a clinical ethnographic approach for use in NHS mental healthcare, making use of specialist cultural consultation experts working alongside care workers.<sup>19</sup> This intervention involved assessing identity, reconciling the cultural health beliefs and expectations of the patient (using Barts Explanatory Model Interview), their social and cultural group, and including care workers’ reflections on their own health beliefs.<sup>19</sup> Referrals were from care professionals or patients themselves, and were driven by conflict or uncertainty about how to tailor care to take account of race, ethnicity and culture. Racism was a feature of patients’ experiences of services, and why professionals sought guidance, fearing they were not skilled at dealing with such matters. The service gathered patient narratives, and took account of psychosocial and structural factors, including racism as a form of trauma, that affected mental state, help-seeking and fear of coercion. The service also equipped clinicians with the necessary vocabularies, insider knowledge and summaries of epidemiological and sociocultural research of relevance to specific patients or patient groups. This meant that the service was able to provide useful care recommendations, for people living with psychoses, mostly receiving care from assertive outreach teams or while admitted to hospital. The outcomes included fewer contacts with assertive outreach teams, and consequential savings at 3-month follow-up,<sup>19</sup> and more confidence in holding such conversations among the professionals. Despite the emerging evidence of value, no NHS commissioned services have adopted this specialist cultural consultation and ethnographic approach. The principles of cultural consultation are being re-discovered, recognised and applied, driven by the interests of specific practitioners rather than by a comprehensive drive to ensure quality standards are devised or met.

To summarise, clinical ethnography permits reflexivity in clinical encounters and opens up the possibility that the clinician’s own values and constructions of race/ethnicity and culture can be considered alongside learning about the social and cultural context of distress, and its expression in a specific patient, with a specific ethnic/racial heritage and identity. The ethnographic interview facilitates the development of rapport and trust and seeks a collaborative process for gathering information, weighing it up and choosing therapeutic actions. In skilled hands, the approach should reduce the power differentials, correct misunderstandings and repair therapeutic ruptures within an ongoing formative process.

### Clinical Ethnography and COVID-19

The coronavirus disease 2019 (COVID-19) pandemic has revealed and escalated health inequalities, especially for racialised and ethnically minoritised people. Yet, there have been few ethnographies of the challenges. Recent rapid ethnographies of COVID contexts in Macau and USA show how a narrow biomedical and quarantine-focused narrative can undermine broader health and wellbeing; and these studies reveal difficulties for patients and for clinicians in adapting to new routines and infection-prevention priorities.<sup>27,28</sup> Stark differences in the spread of COVID-19 and in health outcomes have exposed how racism engenders and reinforces these inequalities. As a consequence, there is a growing awareness that we must adapt health and social care to be, not only culturally competent, but also capable of tackling fundamental causes of inequalities, both the social determinants and racism.<sup>29</sup>

Understanding of the biology of the virus must be pursued alongside interrogation of the political and social contexts of the pandemic.<sup>30</sup> History shows that exclusionary and xenophobic sentiments emerge at the time of pandemics, and these can be as damaging as the virus by exposing and deepening divisions and inequality.<sup>31</sup> Clinical ethnography and broader social sciences approaches such as critical anthropology can challenge the narrow biomedical and structurally bereft lens through which we continue to make mistakes of the past at the levels of policy and practice.<sup>32</sup>

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K.B. conceived of the paper and wrote the first draft. S.D. and C.P. have reviewed the manuscript and made significant contributions to the revisions and in response to reviewers. All authors approve the final draft.

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