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 socio-cultural 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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