Should there be separate psychiatric services for ethnic minority groups?

KAM BHUI / SASHI P. SASHIDHARAN

Edited and introduced by Mary Cannon, Kwame McKenzie and Andrew Sims.

INTRODUCTION

For decades there have been calls for psychiatric services to be more culturally competent. Frustration with a perceived slow pace of change has led to the development of separate services. For instance, in the USA, San Francisco General Hospital has psychiatric wards with different 'ethnic focuses' – East Asian Americans, African Americans and Hispanic Americans are admitted to different wards. In the UK, the National Health Service has developed culturally specific services as well as funding voluntary sector services that target specific cultural or ethnic minority groups. Are such developments the correct way forward? Do they produce lasting change or just let general services off the hook? Can they work in major cities like London, Paris or New York where over a hundred languages are spoken?

We asked Dr Bhui, author of a Maudsley discussion paper on separate services, and Professor Sashidharan, who is currently working on a national plan for ethnic minority psychiatry in the UK, to debate the question: 'Should there be separate psychiatric services for ethnic minority groups?'

The authors borrow heavily from the UK experience but the arguments for and against will have resonance internationally and inform other debates, such as whether there should be specific facilities for women.

FOR

Research evidence demonstrates racial, ethnic and cultural inequalities of access to specialist psychiatric care, and differential assessment and management practices. In the UK, the most consistent findings are a greater use of involuntary detention in hospital, higher rates of admission to psychiatric units and forensic in-patient facilities and a growing dissatisfaction with services over consecutive contacts for Black people of Caribbean origin. Neither these data nor voiced dissatisfaction by many ethnic minority service users have led to systematic changes in the delivery of mental health services in multicultural societies. Societies that tolerate such systems of care must carefully de-structure the processes and procedures by which discriminatory practice has first become enshrined and then sustained within existing systems of care.

Despite contributing more in taxes than they consume in benefits, immigrants to the UK and their children still cannot expect at least equal benefit as citizens from a national system of mental health care. Professionals are still not fully equipped with conceptual and skills knowledge to offer equity in assessment and management of mental distress in distinct cultural groups.

Specialist services for specific ethnic groups have flourished in this climate but mainly within the voluntary sector. These were the only alternatives to statutory care, at a time when mental health policy made little mention of ethnic groups and when issues of culture, religion and identity were subordinate to the policy agenda set for the majority population. But three recent UK events promise improvement: mental health policy now emphasises equity in care provision; National Health Service (NHS) trusts (the providers of care) are named within the Race Relations (Amendment) Act 2000, which makes them legally liable if their services are discriminatory; and the Royal College of Psychiatrists has instigated an inquiry into institutionalised racism within College structures. These recent shifts in policy and awareness have not yet translated into actual changes in practice and service provision. Recent service developments in general psychiatry have not been evaluated in Black and minority ethnic groups, even though they are overrepresented as mental health service users.

The evidence base for the development of special services for specific ethnic groups is sparse; these never attract the political will or funding potential to conduct decisive evaluations. The strength of specialist services lies in the mandate from service users and the commitment from the voluntary sector and the practitioners interested in culturally competent care provision.

Specialist services already exist and are now being adopted in statutory services to engage those most disenfranchised by existing models of care. The competent and comprehensive evaluation of these is still neglected.

So why do we still need specialist mental health services for Black and ethnic minorities? Existing services as a whole do not offer a system of care in which Black and ethnic minorities can expect to receive the least coercive treatment, and nor do they guarantee that cherished cultural, spiritual and religious beliefs are even known by professionals, let alone accommodated into care plans.

Recovery is more than symptom alleviation. Perceived differences between racial and ethnic groups conjure up much racial imagery that is unconsciously introduced into social encounters. These could add to distrust and lower the threshold for assuming incapacity among specific ethnic groups, while neglecting the unfamiliar expressions of distress of other groups.

No one in the caring professions wishes detrimental treatment on any member of the public, irrespective of cultural origins. However, institutionalised practices are not readily recognised by those working within these institutions. Existing statutory services have difficulty retaining staff and attracting and promoting Black and ethnic minority workers, and in addressing the cultural issues presented by patients. The statutory sector is increasingly containing, pursuing, detaining, and managing risk, rather than offering an alternative – voluntary

https://doi.org/10.1192/bjp.182.1.10 Published online by Cambridge University Press

engagement through building relationships which aid recovery and instil hope.

In addition to an inability to address important institutionalised cultural issues, there are also gaps in service provision and in the training and continuing professional development of practitioners.

What alternative is there for Black people who develop mental illness in the UK? Either to subjugate themselves to a failing statutory sector that claims to do the best it can but which is more likely to detain them than their White peers, or to disengage and try to make it on their own – risking forensic service contact. Specialist services offer an alternative. Culturally informed staff develop innovative ways of engaging and working with distressed people from Black and ethnic minority groups. They develop new methods of ensuring engagement and functional improvement beyond symptom alleviation. They focus on personal contact and relationship-building in the context of culturally congruent thinking.

The arguments against specialist services are often economic. What cost do we place on the mental well-being of ethnic minorities? To date, the mental health of Black and ethnic minorities has not been valued highly, with unsuccessful persistence of models of care that allegedly suit the majority. The illusion of a cohesive service continues to exist alongside actual fragmentation of utilisation by all citizens. A true user-oriented service, the benchmark of future mental health services, offers choice and a mixed economy of care suited to the needs of the individual and flexible enough to accommodate difference. Based on the qualitative descriptions and experiences of service users, why do we not have more specialist services and why has there never been a properly funded evaluation of such services? Only in the absence of relevant information can invidious judgements continue to be made, so perpetuating discriminatory practice. If the NHS Plan and the National Service Framework objectives are delivered, there may be no need for specialist services for Black and minority ethnic groups. Until then, why dismantle and ignore a body of experiential evidence that clearly favours their widespread value?

Kamaldeep Bhui Senior Lecturer in Social & Epidemiological Psychiatry, Barts & London Medical School, Department of Psychiatry, Queen Mary & Westfield College, University of London, 327 Mile End Road, London E1 4NS, UK

AGAINST

Whenever Black and ethnic minorities are the focus of discussion why is it that we almost immediately think about 'separate', 'different' and 'them' being not as part of 'us' and therefore requiring 'special' attention, outside of the mainstream? Although most people will acknowledge that we are living in a multicultural society, the separateness of 'cultures' and the emphasis on 'differences' between White and non-White continues to be a major preoccupation within Europe.

No doubt these ideas of cultural or racial differentiation are animated by the continuing legacy and vocabulary of the 'race' discourse of an earlier era and, more recently, augmented by the new racism concerning asylum-seekers and refugees. The consequences of this are obvious in all walks of life.

Within public services, for example in education, law and order, housing and employment, we can see the consequences of such thinking that prioritises race or cultural *difference* over ethnic *inequalities* and, as a result, advocates culturally specific service solutions rather than striving for equality in service provision.

In mental health, where some of the most dramatic and persistent ethnic inequalities are found, a similar approach based on separate and specialist provisions for minority ethnic groups is sometimes advocated, not least because of the collective failure to make any impact on the negative experiences of Black and minority patients so far.

There are a number of reasons why I believe such an approach would be wrong and likely to be counterproductive in addressing the ethnic inequalities that characterise our mental health services.

First, the idea of separate services for different ethnic groups is based on the premise that the mental health needs of minority ethnic groups are somehow different from those of others. There is hardly any evidence to support this point of view. No one doubts the significance of cultural diversity when planning and providing mental health services in a multicultural setting. But we cannot attribute major disparities in the service experience and outcome between majority and minority ethnic groups to cultural differences or special 'ethnic' needs which are inadequately addressed by the services. The more likely explanation for the ethnic inequities that we see within our mental health services is that they are a product of institutional factors, embedded in our professional practice and driven by the culture and history of Western psychiatry.

The newly rehabilitated term of institutional racism provides the most meaningful explanation as to why Black and minority ethnic groups are systematically disadvantaged within our mental health services. If that is indeed the case, the solution for the current problems must involve the mainstream of psychiatric practice rather than marginal initiatives that emphasise further segregation of minority needs.

Another argument against 'specialised' or segregated services for Black and minority ethnic groups is that culture and culturally informed or capable services are important in all aspects of psychiatry and not just in relation to minority ethnic groups. By setting up services that emphasise the significance of culture only in relation to ethnic minorities we not only bleach culture out of the mainstream but also, indirectly, suggest that culture is a problem or disability for minority groups that requires specialised and often moderating interventions. Although such a view resonates with the common racism encountered by many from minority cultures in contemporary Britain, within mental health services we should avoid the pitfalls associated with such simplistic and, in the end, racist formulations around culture and the burden this imposes on minority groups.

By creating specialised services for minority groups which emphasise the centrality of culture, we are recreating the discredited and ultimately colonial discourse of transcultural psychiatry. Furthermore, such marginal attempts to create new services for British people of African and South Asian heritage will allow the mainstream of our services and those working within it to continue turning a blind eye to the needs of our multicultural society. I am not sure whether even the most ardent advocates of cultural psychiatry are ready for such 'Bantustan-isation' of our mental health services.

Over the past three decades there have been several attempts to set up separate services for minority ethnic groups in the UK. Such developments have a particular history and have often been part of the larger struggle of Black and South Asian people against racism, and a product of statutory agencies' failure to provide appropriate services for these communities.

https://doi.org/10.1192/bjp.182.1.10 Published online by Cambridge University Press

There is much to learn from those initiatives; indeed, the mainstream services, in many instances, have been enriched by these experiences. However, the lessons to be learnt here are not about separate developments for Black people or South Asians but how to make our services in general culturally capable in responding to the needs of all cultural groups, both Black and White. This cannot be achieved without addressing the central issue of institutional racism.

If there is a serious attempt to plan and deliver our services with a commitment to tackling institutional racism, then the needs of minority groups will begin to be addressed. Central to this is the understanding that we need to guarantee equality, eliminate discrimination and ensure rights rather than be preoccupied with special needs based on culture or other ethnic characteristics and fashioning new services around those.

We are at a critical point in the reform of our mental health services. We cannot afford to miss the opportunity to achieve fair and equal services for all by the continuing flirtation with outdated ideas from our colonial past.

Sashi P. Sashidharan Medical Director, Northern Birmingham Mental Health Trust and Professor of Community Mental Health, Centre for Community Mental Health, University of Central England, Birmingham B15 3TN, UK

FURTHER READING

Bhugra, D. & Bhui, K. (2001) *Cross-Cultural Psychiatry: A Practical Guide*. London: Arnold.

Bhui, K. & Olajide, D. (eds) (1999) *Mental Health Service Provision for a Multi-Cultural Society.* London: W. B. Saunders.

__, Bhugra, D. & McKenzie, K. (2000) *Specialist Services for Minority Ethnic Groups?* Maudsley discussion paper no 8. London: Institute of Psychiatry.

Cox, J. L. (2001) Commentary: institutional racism in British psychiatry. *Psychiatric Bulletin*, **25**, 248–249.

Department of Health (1999) *National Service Framework for Mental Health*. London: Department of Health.

Francis, E., David, J., Johnson, N., ***et al*** **(1989)** Black people and psychiatry in the UK. An alternative to institutional care. *Psychiatric Bulletin*, **13**, 482–485.

Sashidharan, S. P. (2001) Institutional racism in British psychiatry. *Psychiatric Bulletin*, **25**, 244–247.

https://doi.org/10.1192/bjp.182.1.10 Published online by Cambridge University Press