



**COLLABORATIVE
CENTRE**

- ETHNIC INEQUALITIES
- SEVERE MENTAL ILLNESS
- MULTIPLE DISADVANTAGE

BRIEFING PAPER

The impact of racism on mental health

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The Synergi Collaborative Centre is a national initiative, to reframe, rethink and transform the realities of ethnic inequalities in severe mental illness and multiple disadvantage. Taking a collaborative approach, the centre aims to use the principles of co-production of knowledge and a creative mix of robust research methods. The centre will work closely with commissioners, policymakers and politicians, as well as public service providers, citizens and those experiencing mental distress, to create and deliver a vision to help eradicate ethnic inequalities in severe mental illness and their fundamental causes.

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THE IMPACT OF RACISM ON MENTAL HEALTH



There is much controversy about why some people have poorer life chances, and specifically poorer experiences of health and mental health. One explanation for ethnic inequalities seen in the mental health system, and in society in general, is racism.

The place of racism as a cause of mental illness, or factor that leads to poor health, is contested. This is mainly as the evidence is emerging but also as there are strongly held views, both by people who do not want to talk about racism and those that do.

Racism is an unpleasant reality. However, it exists in many forms and acts not only through interpersonal assaults, but also through societal structures. This briefing has been produced to support actions to improve population mental health, specifically to reduce ethnic inequalities in experiences and outcomes of severe mental illnesses. It summarises the evidence on the impact of racism on mental health, mental illness and its relevance to ethnic inequalities in the experiences and outcomes of mental health services.

The summary of evidence is for use by the public, patients, health staff, commissioners and policymakers. In fact, every person who wishes to eradicate inequalities and improve the mental health of the population. It sets out evidence and explains some of the nuanced and subtle forms that racism can take, and how it affects health.

There is a large and growing body of robust evidence demonstrating that racism leads to mental illnesses, especially depression and prolonged periods of adjustment, like prolonged grief or difficulty coping with and adapting to severe events. The evidence suggests racism is followed by more experiences of hallucinations and delusions; and if physical assault is involved, post-traumatic stress can emerge.^{1-6 7} These mental illness experiences are often co-existent. There is evidence that racism also has an effect on physical health, for example, high blood pressure.^{8 9}

The levels of expressed individual prejudice in the general population, and ethnic minority people's experiences of racism, have remained stable in the population over the last few decades.^{10 11} Frank prejudicial expressions (racist violence, abuse, name calling, etc.) continue to be reported to the police and appear on TV and social media.

RACISM IS DEFINED AS:

- Prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior.
- The belief that all members of each race possess characteristics, abilities, or qualities specific to that race, especially as to distinguish it as inferior or superior to another race or races.
- *Institutional racism is defined as the collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination, either through unwitting prejudice, ignorance, or thoughtlessness and racist stereotyping, which disadvantage minority ethnic people.^{12,13} Institutional racism creates separate and independent barriers to access to and the quality of health care. This does not have to result from human agency, intention or individual prejudice that has a race basis. Racial discrimination can occur in institutions, such as the NHS, even when the institutional leadership does not intend to, or overtly plan to make distinctions based on race, ethnicity or colour. In fact, it can occur without any awareness of it happening.

Race categories have no scientific basis as a source of differential performance or achievement, intellectually or physically. The importance of race is that it is a social marker of identity, allowing the identification of 'the other', and as a way of seeing people as part of collective identity groups.

Racism and attacks on 'other' groups become more prominent when there is a shortage of resources, when other groups may be perceived to be a threat to self-growth and access to resources, such as employment, housing and other benefits. Yet, these views are also persistent as latent ideas and deeply held attitudes about self and other, and they are shaped by historical memories and events that define and influence modern race relations.

Although ethnic and racial group definitions have evolved over time, they were originally used by governments to classify heritage, race and ethnic origin. However, self-defined ethnic and racial group identities are also important for groups organising themselves, to assert their rights and entitlements and to combat discrimination and racism. These identities can afford positive functions, such as social support and a sense of belonging.

IMPACT OF INTERPERSONAL RACISM

Racism can occur at the interpersonal level. For example, prejudicial statements that are hurtful or attacking; aggression, violence, bullying or harassment. These adverse experiences need not be extreme, they might operate on the basis of almost casual slights, so-called micro-aggressions that consist of chronic daily hassles, avoidance of people, places and contexts and thwarted aspirations. Indeed, they need not be directly experienced to have pernicious effects on the individual.¹⁴ Racism can also be enacted by limiting opportunities for some groups of people or by providing unfair advantages to other groups of people.

*<https://publications.parliament.uk/pa/cm200809/cmselect/cmhaff/427/42703.htm>

Compelling evidence shows that racism is a form of stressor, both in its more overt forms and as micro-aggressions, where there is no major incident but an awareness of being treated and responded to in a less than fair way on the basis of race; perhaps even being feared, avoided or especially disadvantaged.¹⁵ These subtle influences can result in pessimism, and difficulties adjusting and recovering from trauma, and there is a growing and convincing body of evidence that psychosis and depression, substance misuse and anger are more likely in those exposed to racism.^{110 16-18}

More explicit verbally hurtful comments about appearance or physical attacks, due to hostility towards a specific race, also cause emotional distress, and lead to mental illnesses - in part because of the direct threat to identity and status, but also because physical and verbal violence lead to injury and post-traumatic stress.

The fear about being victim to assault and racism among ethnic minority people is itself harmful, and undermines resilience, hope and motivation. People of visible migrant or ethnic minority heritage, who see themselves as targets of negative attitudes, are living in fear and this is a chronic stressor, which in turn can affect their children's mental health.^{17 19 20}

THE MULTIDIMENSIONAL NATURE OF DISADVANTAGE

There are many social or demographic gradients of disadvantage linked to exposure to hazardous environments and threats. These include social class, income level, educational experience and achievement, and employment status and urban environments, as well as constraints on employment and access to recognised positions.

These forms of disadvantage are experienced differently by people of different social groups or identities, for example, by people of different ages, genders, sexual identities, religions, asylum seeking status and disabilities, among others. Other types of disadvantage include being unemployed, or street homeless; these groups may also experience prejudice; other characteristics can place people in positions of vulnerability, disempowerment, or disconnection from social and political influence.

These influences intersect with race to lead to different power relationships, and where a person's group is especially affected by specific conditions, these combinations can lead to unequal and unfair outcomes. That is, discrimination can drive inequalities and lead to health problems that then also compound inequalities and social exclusion, as well as causing social exclusion and inequalities. It is these varying types of structural and institutional racism that are especially pertinent to the context in which health providers operate.

STRUCTURAL DISADVANTAGE AND MENTAL ILLNESS

Structural racism is embedded not in individual prejudicial attitudes, but in the way society and organisations are structured, through policies and practices that are accepted as standard and reasonable, but nonetheless result in discriminatory practices and disadvantage some racial or ethnic groups.

The main sources of structural disadvantage include poverty, unemployment, housing, poor neighbourhoods and schooling opportunities.²¹⁻²⁴ These experiences impact on mental health and the effects accumulate over the life-course and are transmitted across generations.^{7 25 26} Life course approaches show that young children, especially Black Caribbean and Black British children, are more likely to be excluded from school, and school exclusion is linked to adult mental illness and also to criminality and substance misuse.^{16 27}

Earlier recognition of those vulnerable to exclusion and the provision of appropriate social and psychological support may avert these trajectories. This is important of itself, but in addition these trajectories are likely to account for the higher risk of criminal justice system pathways into mental health care for people in Black Caribbean, Black African and Black British ethnic groups.

However, even where educational success has occurred, research shows that ethnic minority people have poorer outcomes than White people. For example, those with degrees are less likely to secure employment, and their lifetime earnings are less than those of the White majority population ^{** *** ****}.

Employment is a powerful protective influence, partly because of meaningful activity, social contact and support, and also where pay is sufficient to avoid financial strain. Although discrimination might well result in unemployment, discrimination and racism also result in stress at work for those who are employed. Workplace discrimination can take the form of limited promotion prospects, unfair working conditions, performance reviews that are failed because objectives are unreachable, or when training and support are not provided.

Some groups have stronger associations between racism and common mental disorders, for example, people of Black Caribbean and Black African origin compared with people of White British ethnic origin, although the effect is apparent for all ethnic groups including White Other and Irish ethnic groups.^{5 28} There are gender-related additional risks: Black women in the workplace are more likely to report workplace stress related to racism.^{6 28}

PATHWAYS TO MENTAL HEALTH CARE

It has been suggested that the nature of the illness among ethnic minority people is more severe, including more violence, co-existing substance misuse and chaotic behaviour, or suicidal thinking, or paranoia. There is, however, little evidence to support such a claim. There may be a fear of racism from institutions invested with authority and power, and so these are avoided. The generalised concerns of a threat from a society that is socially excluding, or as a result of being a victim of racism and discrimination, are all real concerns.

**<https://www.theguardian.com/world/2017/oct/07/ethnic-minorities-jobs-gap-bame-degrees>

***<https://www.theguardian.com/education/2016/jan/30/ethnic-minority-graduates-earn-less-struggle-to-build-careers>

****<https://www.gov.uk/government/publications/race-disparity-audit>

The pattern has remained consistent over many decades: greater admission and detention rates among ethnic minority groups, especially Black patients, more specifically Black Caribbean, Black British and Black African patients. People in these groups also experience less primary care management of their illnesses, and more access through forensic services, the criminal justice system, including section 136 whereby the police take people to a place of safety to be assessed for section 2 or 3.^{4 29-31}

Early school exclusion, traumatic experiences, material deprivation and early contact with criminal justice systems may be implicated in first episode psychoses and lead to adverse pathways to care. Actions earlier in the life course, in schools and early opportunities to improve social engagement and skills, will mitigate this, but are also important avenues to knowledge about potential sources of coping and help.

There is evidence that consecutive contacts with services lead to disengagement over time, perhaps resulting in avoidance on the part of the service user. This may explain more assertive and coercive responses from clinicians in services where they fear deterioration in mental health coupled with concerns about risk.³²

Some studies have shown that social isolation and not having an advocate is associated with greater detention risks in Black patients.^{31 33} One of the explanations proffered for this in the literature is that informant histories are not available, and therefore assessments are necessarily partial. But it may be that the lack of someone taking up the advocacy role in the context of stereotyped assumptions, is a key issue for Black patients, or that the absence of an advocate may risk more detention for all patients who are isolated.

The pathway into mental health care for ethnic minority people is generally unremittingly aversive.²⁹ Research has demonstrated under-recognition of mental health problems in primary care, and care pathways that lead to contact with the police and the criminal justice system. For example, personality disorders are less frequently diagnosed in Black than White patients, and especially in forensic care systems for Black patients.³⁴ Could it be that the precision of assessment is poorer for some ethnic groups?

Studies of personality disorder show that the precision of diagnosis is better with structured interviews rather than clinical diagnosis (based on judgement in routine practice). Therefore, routine practice may lead to poorer diagnostic practice, especially when decision-making might be influenced by racialised stereotypes and concerns about risk.

In reality, there is little evidence that Black patients are more likely to be violent to others or to harm themselves.^{35 36} In addition, mental illness is frequently not recognised in remand prisoners, and this may be worse for Black remand prisoners.^{37 38} Improved court diversion may help, with a specific focus on assessing psychopathology across ethnic minority groups, even in contexts where there is little time or space to undertake a comprehensive assessment.

CONCLUDING COMMENTS

Ethnic minority people, when compared to White British people, are more likely to report adverse, harsh or distressing mental health experiences and poorer outcomes, if they develop a mental illness and are in contact with services. These experiences are persistent and driven by societal disadvantage, framed by institutional and interpersonal racism.^{20 25 26}

Ethnic inequalities in mental health care systems have been documented for at least three decades.^{4 5 12 39-42} These experiences include higher rates of compulsory admission and treatment (often referred to as detention or sectioning) and being subjected to forcible treatment, seclusion and restraint.

Ethnic minority people (in particular, Black ethnic groups) are also more likely to have involvement with the police and the criminal justice system en route to receiving health care.^{30 31 43} This is true in first illness episodes as well as among those with ongoing mental illnesses.^{35 36} There is also evidence that some ethnic minority groups are less likely than White British people to receive help and treatment from their General Practitioners (GPs).^{31 44}

There are many reasons for the different experiences of ethnic minority people compared to White people in relation to mental health care. One set of explanations is based on the notion of structural racism and institutional racism. This means the way that institutions, such as health agencies, organise practices, policies and priorities, reflect and replicate power dynamics in broader society.^{12 13 45 46} This then has an adverse effect on ethnic minority groups compared to White majority groups. This can happen knowingly or unknowingly, but becomes established as ordinary behaviours, attitudes and practices within the institution.

Institutional racism in organisations, such as mental health services, refers to not just unequal treatment of different ethnic groups but unfair outcomes. It reflects a continued tolerance of such practices and a failure to monitor, challenge and change such discriminatory patterns of care and treatment.

The power relationships within organisations, lack of alternative perspectives and the prioritisation of race-blind business efficiency compound the hurts already experienced, and add to the health burdens of individuals, communities and society.⁴⁷ The structural power relationships also serve to maintain these unequal outcomes, with justifications being pursued through multiple and often competing narratives which fail to grasp what is at stake for ethnic minority people: their health, their dignity, a sense of justice and trust in peers, society and its institutions.

Societal and institutional injustices can become problematic, if persistent, and traumatic, if they reinforce injustices of more violent discrimination or social adversity. Furthermore, developing a mental illness might be experienced as traumatic and frightening, and should encourage help-seeking. Perceived barriers to care, such as perceptions of racism, can undermine necessary help-seeking and support.

Institutional racism is not the only reason why ethnic minority people have a worse experience of mental health and of the mental health system, when compared with White British people.

Often, there are major differences between the life experiences of people from ethnic minority groups and the majority group, their social and economic background and the opportunities, status and power they are afforded in society.

For example, Black children growing up in deprived urban environments will have poorer life chances because of school exclusion and materially deprived environments. In such social and physical environments, they are more likely to experience greater adversity and trauma, and also have poorer protections against such negative and damaging experiences.

These structural disadvantages may not result in or be mediated by the use of racist language or hostility, but they unwittingly operate together to compound ethnic disadvantages. These in turn may lead to poorer likelihoods of successful life chances, employment, sufficient income and greater emotional strain. Societal racism then sustains such institutional systems through political and social processes that challenge the principles of equality of opportunity and outcomes.

The lack of recognition and awareness of the role of racism in mental health care, and its role in generating and perpetuating ethnic inequalities, has many consequences:

- For those who require treatment, the ability to access appropriate therapy at a time they need it is potentially limited if services are seen as unwelcoming or negative, and are stigmatising; if people's personal experience and fears of racism are not taken seriously or denied - not least if they have experienced racism - the fear may be of not being believed, or of having to make accommodations and tolerate indignities, or their experiences may be more indirectly or subtly denied. The experience of not being heard, or being mistrusted, or being treated with hostility, are commonly expressed by services users, and reveal implicit power dynamics that act as a context for inequalities.
- Service users from ethnic minority groups will continue to experience poorer care or more coercive care, or no care. These negative experiences are self-fulfilling and sustain the perception of care systems as harmful, and obscure more positive experiences.

THE SYNERGI COLLABORATIVE CENTRE

We are developing, promoting and testing collaborative leadership as an essential ingredient of our work. By placing the real life stories of people at the heart of any analysis, we aim to co-create a more complete picture that does not lose sight of what is at stake, and which attracts and motivates everyone to tackle racism.

We are gathering the life stories of people who suffer poor mental health, and people who, like us, are concerned about how racism affects mental health and may be a driver for mental illnesses.

We welcome your stories through our interactive website and in our planned series of narrative-based workshops and participatory research over the coming months.

We also wish to hear positive stories, about survivors, how to overcome racism and its pernicious effects and which interpersonal, institutional and societal or structural actions and policies are effective.

We are co-producing with the public, service users, commissioners and policymakers as well as clinicians, for actions that are effective in the care services and in populations. Professional membership societies, training bodies, care services and regulators all need to engage in a unified approach to tackle racism, taking account of the systemic nature that an effective approach must take.

We want to hear more about how education and training, leadership, and quality assurance can be better integrated in health care, in public health practice, including local and national government, and in society at large.

We will be launching a national 'priorities in research in practice and policy' exercise in the coming months.

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ABOUT SYNERGI BRIEFINGS

Synergi Briefings provide evidence summaries, and reflect Synergi's position, approach and values, to build a fairer health care system, and to improve population health. Although embedded in the published evidence, there is much evidence in practice and in unpublished sources, or on websites, or in the memories of organisations that work with ethnic inequalities.

We welcome these other sources of evidence and will place them in co-production spaces to develop shared narratives of evidence, and actions which can be taken, to prevent and reduce ethnic inequalities in the experiences and outcome of severe mental illness, and which take account of multiple disadvantage.

We welcome use of the content and discussions about progressive approaches to enhance health and social systems.

Our briefings are free to use, but please do provide the citation as suggested inside the front cover.

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