Commentary: Ethnicity, Race, and Forensic Psychiatry—Is Being Unblinded Enough?

Kwame McKenzie, MD, MRCPsych

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Psychiatric treatment is a dialogue among individuals, their communities, and service providers. For any dialogue to be effective, there has to be mutual respect and understanding. One-size-fits-all concepts of psychiatric diagnosis and treatment are unlikely to lead to effective dialogue and are unlikely to produce equitable treatment for ethnic minority groups. Seen from this perspective, color-blind approaches to the treatment of diverse populations are facile. But seeing one approach as facile does not necessarily make the development of appropriate solutions easier.

Dr. Hicks,[1] in a wide-ranging and provocative article, reviews the literature on ethnic bias in forensic psychiatry and posits that forensic psychiatrists need to develop skills to become capable of dealing with diverse communities. Improving clinical formulations, increasing objectivity, and giving attention to validity of scientific assessment by expert witnesses are all considered important tools in this regard. It is not clear, however, that such an approach is sufficient.

Even if forensic psychiatrists were better at dealing with African Americans, there would still be a disproportionate number of African Americans going through the forensic system.

Dr. McKenzie is Senior Lecturer in Cultural Psychiatry, Royal Free and University College Medical School, and Honorary Consultant Psychiatrist, Barnet Enfield and Haringey Mental Health National Health Service Trust, London, UK. Address correspondence to: Kwame McKenzie, MD, MRCPsych, Royal Free and University College Medical School, Rowland Hill Street, London NW3 2PF, UK. E-mail: k.mckenzie@rfc.ucl.ac.uk

Toward the Development of Equitable Services

Equitable services are built on in-depth analysis of the problems at hand. Before trying to provide a solution to make forensic psychiatrists more culturally capable, one may want to investigate why disparities exist between ethnic groups in rates of illness and admission to forensic services. One would have to ask whether making forensic psychiatrists culturally capable is a valid aim or whether developing services based on equity of efficacy across the board would be a more appropriate response.

The investigation of pathways to care highlights the complex forces that bring patients to our treatment rooms.[2] It could be argued that understanding such pathways is important in helping us to decide where intervention is best targeted. This may be long before patients come into contact with forensic services.

Such investigation is easier in the United Kingdom where there is a National Health System. Because health services are funded by the government and are free to all citizens, there are fewer differences in access or provision of care and so comparisons between ethnic groups are more easily made.

The British population of African and Caribbean origin makes up three percent of the population. They are relatively recent migrants from British colonies who were invited to the United Kingdom to fill postwar labor shortages between 1950 and 1970.[3]

There are many problems in trying to equate the situation of this group with that of African Americans. No direct comparison is possible, but it is rea-

sonable to use the situation of a different black minority group in a predominantly white country to illustrate the complexity of the situation.

High Rates of Use of Forensic Psychiatry

Over-representation of patients of African or Caribbean origin in the United Kingdom is found at all levels of inpatient psychiatry, but is greater as the level of security increases.[4,5] U.K. general psychiatric hospitals have three levels of security: open wards, locked wards, and psychiatric intensive care units. Patients who are mentally disordered offenders or who are considered too dangerous to be looked after by general psychiatrists may be transferred to low-, medium-, or high-security forensic psychiatry units.

Ethnicity is an important independent predictor of admission to psychiatric medium or high security units.[6] Black patients of Caribbean origin are up to 10 times more likely to be admitted to medium-security units.[7–11] The reasons for this disparity are complex, but they do not simply reflect poor treatment or judgment by forensic psychiatrists.

Patients with a diagnosis of a psychosis are more likely to be admitted to psychiatric forensic units than those with other diagnoses. Studies have demonstrated that people of Caribbean and African origin are two to six times more likely to receive a diagnosis of schizophrenia in the United Kingdom.[12–14] African-Caribbean individuals admitted to medium security are more likely to have a diagnosis of psychosis than whites.[9] The over-representation of African-Caribbean persons in medium security may therefore reflect, in part, the higher likelihood of admission to forensic units of those with a diagnosis of psychosis and the higher rates of psychosis in the African-Caribbean population.

However, this hypothesis does not explain the fact that the over-representation of African-Caribbean individuals in psychiatric care increases as the level of security increases.

An alternative explanation for the disparity in rates of admission to hospitals and to forensic services between ethnic groups with psychosis could be that African-Caribbean people with psychosis are more likely to be detained in psychiatric hospitals against their will than are their white British peers.[9,15] Those who are admitted involuntarily are more likely eventually to be referred to forensic services.

But the rate of involuntary admission may reflect the same process that leads to increased rates of acceptance to medium security rather than being an explanation for the over-representation of African-Caribbean patients in this setting. There may be common factors that lead to the increased rates of involuntary admission and admission to medium security.

Pathways to and Through Care

The increased rate of involuntary admission reflects the different pathways to and through general psychiatric care taken by African-Caribbean people and British white patients with psychosis.[16]

African-Caribbean individuals with psychoses have been shown to have a greater delay from first symptoms to diagnosis and treatment.[17] This may in part be the result of the attitudes of African-Caribbean persons in the United Kingdom to the mental health services, but may also be due to two service related factors:

1. Attendance and referral by a family doctor (known as a general practitioner in the United Kingdom (GP)) results in the quickest receipt of services. However, at first presentation, African-Caribbean patients are less likely to have a GP and less likely to have been referred by a GP than are British white patients.[16]

2. African-Caribbean patients who do see their GP and have a diagnosis of a mental illness made by a primary care physician are less likely than British whites to be treated by this primary care physician. They are more likely to be referred to a mental health unit, and this leads to further delay before treatment because of waiting lists and nonattendance.[17,18] Delay in receiving medication has been linked to more subsequent difficulty in treating positive psychotic symptoms and worse symptomatic outcome. The increased use of medium security could be a long-term consequence of poorer initial symptom management due to later presentation. In addition, delay in presentation may also result in African-Caribbean patients' being more symptomatic at first presentation and being more likely to be referred to locked wards and intensive therapy units. Patients who start their psychiatric careers in locked wards are more likely to enter medium security eventually.

Differences in the rates of involuntary admission for African-Caribbean persons and British whites at first admission are also explained by differences in the number of each ethnic group who have a GP in-

volved in their care at the time of referral. Once the involvement of a GP is taken into account, there is no difference between African-Caribbean individuals and British whites in the likelihood of involuntary admission.[16]

Again, this is not the whole story and does not by itself explain why African-Caribbean patients are more likely to end up subject to more coercive care, because after first admission the situation changes. There seems to be a more negative interaction between services and individuals of African-Caribbean descent than between services and British whites. Following first admission, African-Caribbean patients are more likely to be readmitted against their will whether or not they have a GP.[12] They are less likely to comply with medication and less likely to be engaged in community follow-up. Young African-Caribbean patients are less satisfied with services.[19] This poorer satisfaction may be based on differences in treatment offered to black and white patients. The poorer engagement and compliance leads to poorer symptom control and more social disability. These are both associated with higher rates of violence. The services react to poor compliance and engagement by the use of more coercive treatment strategies such as admission to the hospital involuntarily. These strategies lead to appropriate treatment in the short term, but after admission may increase the level of resistance to treatment, noncompliance, and violence and may decrease the level of satisfaction with services.[10,20,21] The over-representation of African-Caribbean patients could be due to the negative interaction between services and African-Caribbean individuals leading to increasingly coercive treatment strategies—hence, medium security.[9]

However, it should be stressed that the poorer engagement and satisfaction may be based, at least in part, on differences in treatment. A recent survey showed that people of Caribbean origin are more likely to be treated with antipsychotic medication and less likely to be treated with psychotherapy even when diagnosis, length of illness, and sociodemographic factors are taken into account.[22]

Links Between Forensic Psychiatry and Other Institutions

A further possible explanation of the over-representation could be the links between forensic psychiatric services and other sectors in which disparities are present. African-Caribbean individuals are over-represented in the prison population and in those who are charged with criminal offenses.[23] There is also some evidence of racial bias in the way that mentally ill people are dealt with at several points in the criminal justice system,[20] which could result in a bias toward the use of security in psychiatric placement. Direct referral from the prison justice system rather than through the psychiatric system may account at least in part for the over-representation. Those who are referred from the courts, prison, or institutions for young offenders are more likely to be placed with forensic services and more likely to be accepted in medium-secure units. However, there are no data to support the assumption that this disparity explains the over-representation of African-Caribbean individuals in medium security.

A summary of the foregoing argument would be that the higher rates of psychosis in African-Caribbean people in the United Kingdom compared with British whites does not account for the higher rates of African-Caribbean persons in psychiatric medium-secure units. Over-representation may be due to differences in pathways to and through care and an interaction between the services and African-Caribbean patients. Of course, the situation is even more complex than this.

The Wider Social World

The higher rates of psychosis in people of Caribbean origin in the United Kingdom are not reflected in the rates in their countries of origin.[24] Social factors are considered etiologically important, and that of greatest current prominence is racism. People of Caribbean origin who are the victims of racism are three times more likely to suffer from a psychosis.[25] In addition, readmission to hospital due to violence depends as much on the area that a person is discharged to as it does on clinical factors.[26] Disparities in educational achievement, the number of single-parent families, the quality of housing, the unemployment rates, and provision of social safety net assistance and support are all important as well. Drug misuse reflects social norms in an area rather than ethnicity.[27] Hence, the rates of illness, types of presentation and comorbidity have powerful environmental influences currently outside the remit of psychiatric services. Though important for our profession, it may be that improving the cultural ca-

pability of forensic psychiatry alone is unlikely to make a significant impact. Psychiatrists may target improving forensic services as important, but in the United Kingdom the public is more interested in decreasing the number of patients of African and Caribbean origin who require forensic services.

Conclusion

It would be hard to fault Dr. Hicks' landmark work, but it is difficult not to note that context has not been taken into account. If the wider forces that shape our practice and the links between forensic services and other psychiatric service are not taken into account, it is difficult to see how outcomes will fundamentally change. There is much that could and should be done to improve individual practice, but I argue that it is likely that in the United States, as in the United Kingdom, the key to systematic service change is to unravel institutionalized discrimination and offer truly equitable service.

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