



The Psychiatric Eye

The London Division eNewsletter



'Racial Equality in Mental Health - Key Challenges, Successes and Learning'



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Editorial

25th May 2021 marks one year since the tragic death of George Floyd. The protests that followed highlighted the injustices and inequities that exist in society today. The COVID-19 pandemic has had further disproportionate impacts on ethnic minority groups. The disappointment felt by many following the publication of the Sewell Report served as an example of why we must not give up the fight for anti-racism.

The theme of this issue is 'Racial Equality in Mental Health - Key Challenges, Successes and Learning'. Equality aims to promote fairness and equity builds on this, demanding that individual needs are taken into consideration.

In mental health services, the racial disparity which exists is evident and the Royal College of Psychiatrists has stepped up and shown commitment to Equality, Diversity and Inclusion. [The RCPsych Equality Action Plan](#) sets out a plan to promote equality and equitable outcomes for College members, staff, mental health staff, and patients and carers.

The strong passion around this topic has been shown through the range of submissions to this edition. Thank you to everyone who submitted an article which includes a powerful piece by RCPsych Chief Executive, Paul Rees, interviews with Dr Lade Smith and Dr Rajesh Mohan, RCPsych Presidential co-leads for Race and Equality, as well as two Culture Vultures and a poem. Congratulations to the winners of the best article; Julia Ogunmuyiwa, Preety Das, Catherine Polling and Vishal Bhavsar, who reflect on racial injustice in Mental Health Services.

Special thanks to our Guest Editor Dr Julia Ogunmuyiwa whose input has been invaluable for this Edition. As an Editorial Team it was agreed to reject the use of the term "BAME" or "BME" throughout this newsletter. Finally, it is with a heavy heart that after five years with The Psychiatric Eye we say goodbye and wish good luck to one of our Editorial Team, Matthew Francis.

We hope that you all enjoy this edition and feel inspired by the thought-provoking articles.

Sonya and Matt



Chair's Message

By Dr Peter Hughes



There are few topics as important as that of diversity and racism in mental health. I recall on my first day as a Consultant Psychiatrist being told by an angry patient, "all you want to do is lock up Black people!"

It can sometimes seem that way when we see our wards and the forensic system. The evidence is there, Black people are disproportionately detained under Section and disproportionately enter the forensic system.

The death of George Floyd on 25th May 2020 started a global discussion but we know in mental health that the disparities and inequities around race have long preceded this.

The recent Report from the Commission on Race and Ethnic Disparities stating that there is no institutional racism rung untrue for many. The Royal College of Psychiatrists has said as much in response. Indeed, the College has taken on the cause of combatting racism as one of its priority areas.

In London, we have the most multicultural and diverse parts of the UK. The issues are accentuated here.

The London Division is proud to devote this Newsletter edition to this important topic.

We hope that it will inspire and help us all to understand how race and diversity relate to mental health.

Dr Peter Hughes

London Division Chair



‘Are we listening? Reflections on racial injustice in Mental Health Services’

By Dr Julia Ogunmuyiwa and Dr Preeti Das (joint first authors), Dr Catherine Polling, and Dr Vishal Bhavsar

Personal Reflections of a Black Psychiatrist

The month of May marks the anniversary of George Floyd’s death. Whilst shocking to see such blatant disregard for his dignity and life this event forced many of us engage in meaningful discourse around race. I have since observed parallels between this event and my experience as a clinician working within mental health services. Black patients are over-represented in these services and encounter disproportionate levels of restriction while at the mercy of senior clinicians who are rarely able to identify with their racial experience.

In most instances “at the mercy” translates to decisions about whether they will be detained in hospital, or have medication enforced. However, in the cases of Seni Lewis, Kevin Clarke and Sean Rigg this power extended beyond authority over their basic freedoms. All tragically died whilst under the care of mental health services, as a consequence of physical restraint. The similarities between these events forced me to acknowledge my own internalised racism and how I might be complicit in the systematic oppression of Black people in these services. It feels necessary to challenge restrictive practices that many of us have become desensitised to. The aftermath of George Floyd’s death provided a unique opportunity for voices that are often dismissed as aggressive to be heard as the world finally appears to be listening.

I now understand the mix of emotions I have felt to be mourning. How could I grieve the loss of a total stranger? I soon realised it was because he represented the experiences Black people have been subjected to in varying degrees throughout history resulting from institutional and structural racism. There may be a temptation to disconnect one’s self from the horror of this event and locate it as a problem in a distant land far away from the United Kingdom. After all the report published from the commission on race and ethnic disparities has rejected the idea that UK is institutionally racist. Perpetuating this narrative has not only been dismissive of the experience of many people from Black and minority ethnic backgrounds but is sadly a missed opportunity to reflect, acknowledge and heal.

Reflections from Maudsley Cultural Psychiatry Group

The Maudsley Cultural Psychiatry Group is formed of ten psychiatrists, psychologists and researchers. We span all levels of training and aim to operate on a non-hierarchical basis with rotating leadership. The Group is both personally diverse and members have dual professional backgrounds in sociology, anthropology, public health and cultural studies. Our agenda has been to address issues of racism and culture in our training and education, using experiential, academic and creative platforms. We formally collaborate with the Maudsley Postgraduate Department, Race and Equality leads at the Royal College, and the IoPPN Health Inequalities Research Group.

Early in our journey, we co-presented a Grand Round with a colleague of ours; a Black British psychiatry doctor who, herself, grew up in the community served by the Maudsley Hospital. She described on-call experiences reviewing a young Black man from a similar background who spent repeated and prolonged periods in supervised confinement. She spoke about the difficulties staff had in seeing this man’s humanity in the context of brief “snapshot” reviews in such an alien environment, and the lack of reflection on his own experience of trauma and the way his social context had shaped his relationship with violence. She also spoke about her own internal conflicts: feeling complicit in the maltreatment of another human being alongside helplessness in the absence of other options and well-founded fear for the safety of staff and other patients. This opened up a discussion on coercion, the impact of working within racist systems for people of colour and the challenges to having thoughtful discussions about race between people of different races.

Our experience of embarking on reflective work publicly has taught us a lot about the challenges of anti-racist work within psychiatry. The presentation connected powerfully with its audience, with many profoundly moved by its emotional honesty and previously unheard perspective. Its uniqueness reflects the difficulty and risk for staff from racialised minorities in speaking about these issues. Following the presentation, we had many sources of feedback signifying that such a presentation had never before been heard in the Trust. In addition, we have been contacted by the Care Quality Commission to present our work nationally, to share our learnings at a wider level.



As a Group we aim to embody anti-racist ideology within our own formation and practice. We recognise that within institutionally racist structures, the impact of inequality serves to oppress and silence people of colour from expressing their authentic experiences. This silencing has a downstream impact of obstructing the understanding, processing and expression of racial trauma on the individual; in turn, our stories often remain unprocessed, unshared and unheard, leaving the status quo unchallenged. In doing our work, our Group aims to invert the impact of this power hierarchy, such that the voices of silenced and disempowered people of colour are centralised and heard – both authentically and clearly. For months in advance, we worked closely with our colleague to prepare the presentation, in order to build a strong foundation of trust and safety. Within the Group, people of colour used a combination of their own lived experience of racial trauma, psychological understanding and sociological theory to inform the process. The wider Group (including both White and senior allies) served to powerfully extend this containing structure, in order to subvert the power hierarchy – with the ultimate goal of providing a platform that centralises and empowers previously oppressed voices.

The presentation urged us to consider the roles demanded of staff from racialised minorities within the psychiatry workforce. Their presence, and the diversity it signifies, is often seen as a marker of an organisation doing well on race equality. However, the presentation spoke to the limited ability to effect change for a Black doctor within a larger system whose power structures are overwhelmingly white. Being one of the few creates intense pressure to assimilate into the prevailing culture and a sense of vulnerability that makes it hard to identify problems at the risk of being identified as the problem.

Following the presentation, we also reflected on the reality that our Group will be vulnerable to external projections from the structure in which it is embedded. It has been strengthening for us to form cohesive collaborations with existing senior leads within our institution. In addition, we continually reflect on our processes, in order to any avoid tokenistic contribution. A significant and developing aspect of our work has involved the formation of a co-production working group; that involves a range of community stakeholders, to bridge the gap between institutional practice and local communities in the longer-term.

As we develop our work, we aim to maintain the integrity and focus on the principles from which we began. This means embodying anti-racist practice by empowering and centring the voices of people of colour, from conception;

while drawing on expertise from disciplines outside of psychiatry including sociology, public health and critical race theory, to provide the concepts and language we need to understand and articulate our experiences. It also means each member of the group reflecting on their own power, based on race, other identities, seniority and academic backgrounds; our awareness aims to provide the safety needed to make meaningful and reflective work possible, without re-enacting the racialised power dynamics we seek to dismantle.

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Race Equality at the RCPsych

By Paul Rees

The appalling murder of George Floyd, in May last year, highlighted to the world the problems caused by systemic racism. While the recent conviction of his killer, Derek Chauvin, secured some form of justice, there is a long way to go to achieve race equality both in America and across the Western world. Here in the UK, the recent Sewell Report on race and ethnic disparities painted a picture of a society where racial equality is widespread, with the impact of structural factors in ethnic disparities being of limited relevance. The report sparked outrage from many people with lived experience of racial discrimination, with the anger and upset they felt only serving to highlight just how potent race and racism still are in the UK. As a Black man, who has lived and grown up in the UK, and experienced and witnessed racism throughout my life, I had similar feelings about the report.

At the RCPsych, we recognise the impact of racism on Black, Asian and Minority Ethnic people. In 2018, we issued a position statement which said:

“We recognise that racism and racial discrimination is one of many factors which can have a significant, negative impact on a person’s life chances and mental health. We are particularly concerned about the disproportionate impact on people from Black, Asian and Minority Ethnic communities, notably those of Black African and Caribbean heritage. In the UK, there are persistent and wide-ranging inequalities for people from Black, Asian and Minority Ethnic backgrounds, increasing their likelihood of being disadvantaged across all aspects of society compared to those from other backgrounds. An individual from a Black, Asian or Minority Ethnic background is more likely to experience poverty, to have poorer educational outcomes, to be unemployed, and to come in contact with the criminal justice system. These, in turn, are risk factors for developing a mental illness. These individuals are also less likely to receive care and support when they need it.”

Last year, Dr Adrian James was elected as our new President on a platform of promoting equality, diversity and inclusion, and, in January, we published a 29-point three-year Equality Action Plan. Through the RCPsych Equality Action Plan, we hope to promote equality for College members and staff, as well as for NHS workers, and patients and carers.

Among many other things, our Equality Action Plan pledges to:

- Promote equality for all psychiatrists in their places of work, by assessing data on the experience and outcomes of different groups of doctors – for instance SAS doctors – in career progression, appointments, leadership roles and referrals to regulators, and by engaging with members to understand their experiences, and developing guidance to support employers to stamp out discrimination
- Campaign to persuade healthcare providers to ensure that training around equality, equity, the impact of unconscious bias on decision-making, structural inequalities and power differentials in mental health are mandated for all mental health staff
- Actively contribute to and support the work of the NHS Race and Health Observatory
- Set up a quality improvement collaborative to promote the implementation of the Advancing Mental Health Equality (AMHE) resource methodology across mental health services
- Champion and support the implementation of NHS England and Improvement’s Patient and Carer Race Equality Framework
- Lobby the Department of Health to ensure recommendations related to reducing racial disparity in the Mental Health Act review are fully reflected in the Mental Health Act Whitepaper, and the subsequent legislation and implementation plans
- Support and encourage all health bodies and providers to make better use of mental health service datasets including the number of detentions, the frequency of detentions, the length of stay, age, sex, ethnicity, and other protected characteristics to underpin equitable outcomes in service delivery.



Delivering all the points in the Equality Action Plan is a top priority for our College – and progress against meeting all the objectives is reviewed every month internally. But we want to do more than just deliver the Equality Action Plan. We want to promote an inclusive approach across the College membership and beyond. Therefore, we will continue to celebrate Black History Month and South Asian History Month each and every year – to highlight the key role that our Black and South Asian members play within the College and across psychiatry. These celebrations will incorporate a wide range of events, blogs, videos on our website and social media content. Since we started to mark the major diversity events – including Pride and International Women’s Day – two years ago, many Black, Asian and Minority Ethnic members (as well as women members and members who are LGBTQ+) have got in touch with us to say that, at last, they feel included by the College and that they are proud of our inclusive approach.

Having started out on this journey of promoting equality, diversity and inclusion, building on the work of many leading College figures of the past, such as our former Presidents Professor Dinesh Bhugra and the late Dame Fiona Caldicott, we are determined to keep working on this as one of our priorities until the cancer of systemic racism, and other inequalities, has been tackled head on – across society – once and for all.

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Paul Rees
CEO, Royal College of Psychiatrists



Facetime: 'Dr Smith and Dr Mohan discuss Race Equality in Mental Health'

by Dr Sonya Rudra



Dr Lade Smith: RCPsych Presidential co-lead for Race and Equality, Consultant Psychiatrist, Clinical Director at South London and Maudsley NHS Foundation Trust, Clinical Director for the National Collaborating Centre for Mental Health.

Dr Raj Mohan: RCPsych Presidential co-lead for Race and Equality, Chair of the Rehab and Social Psychiatry Faculty, Rehabilitation Psychiatrist at South London and Maudsley NHS Foundation Trust.

What to you is Race Equality?

Dr Smith: Ideally, what we would be trying to achieve is equity. What that means, in terms of the people who use the services, is achieving the same access, the same experience, the same outcomes, and then, ideally, the same high-quality access, experience, and outcomes as everyone else gets.

Race equality implies that people get given the same things and that's not what we need. Some people need different types of support, depending on their characteristics. So I would want race equity, for everybody.

Dr Mohan: What we want to see is no disparities based on race and ethnicity in mental health. In order to do that, you have to tackle structural factors that lead to people becoming unwell and lead to people needing hospital admissions.

What is your personal experience of race inequality and how did you become involved in the drive for racial equity or equality in the College?

Dr Mohan: I came to the UK as an International Medical Graduate. I was really surprised to find an excess of Black patients in inpatient psychiatric wards. At that time, more than two decades ago, there was so little understanding about what was going on and not enough questions were being asked. When the College made a really big decision in 2020 to advance Equality and Diversity, as one of their strategic objectives the next term under President Adrian James, this was the opportunity for us to contribute and do something, so I was lucky enough to be chosen as one of the Ethnicity Leads.

Dr Smith: For me, I'm actually British born, British trained and when I went to Medical School I started psychiatry and was really struck by the fact that there were lots more Black people than you'd expect on the ward and that they disproportionately were diagnosed as having psychosis. I was really surprised because I knew lots of Black people but didn't know any who had psychosis. When I went on the wards I found that some people really did have some major issues and I was very interested in the area. I decided to become a psychiatrist and I had an excellent Consultant, who said to me: you need to be mindful that if you start off doing research in race and ethnicity, that is all you'll be known for. And people will undermine that because you're Black. I hope now, 28 years later, things might be different. Black people are much more likely to end up in hospital, much more likely to end up in the higher end of services, in intensive care, in forensic services, much more likely to have physical health problems, much more likely to be given large amounts of medication, etc. So I actually did research into all those areas, which impact Black people disproportionately. If I can make a difference to those areas then that's going to hopefully have a bigger impact on Black people.

In terms of personal experiences of racism, there's so many, especially from when we were younger, from staff and patients. So many micro aggressions, so many very overt things that would happen that would never happen today, and then the systemic and structural discrimination that we all experience, every day.



Dr Mohan: You have to work twice as hard to get to the same place, and in order to sustain your skills or your knowledge and your authority in a certain area. Despite many years of experience, you have to prove it over and over.

You know this is going on as, for example, people in Black, Asian and Minority Ethnic groups are not promoted in the same way as non-Black, Asian and Minority Ethnic groups, so there are barriers at every stage of your career.

What is the biggest challenge we face when tackling race equity in mental health?

Dr Smith: There has to be an understanding and a recognition of structural discrimination; structural racism. I think one of the biggest obstacles to overcome is people refusing to acknowledge that structural factors exist, and, unfortunately, we've got that happening at higher levels of leadership in the country. People perhaps acknowledging it but failing to understand what they need to do to address it, or, even worse, not wanting to address it, because it feels too frightening. They feel as though it's going to change the status quo and that's going to somehow diminish their position in society, and actually it won't. The fact is: morally, ethically, legally, it's the right thing to do, but the cost of having a more equitable system, not just in mental health but across the economy, is 24 billion pounds.

The recent Mental Health Act review highlighted disproportionate detentions of non-white people. Is this related to structural barriers?

Dr Smith: I was involved in the Mental Health Act review and involved in developing the recommendations and writing the Mental Health Act Review African and Caribbean Working Group [report](#). To address structural barriers, you have to start changing the policies, procedures and processes of institutions. You have to look at the inaction that happens around young children, particularly young Black boys who are disproportionately excluded from school at a young age. They're filtered off into the criminal justice system. There are all these structural factors that essentially result in discrimination. These are factors that exist long before a person comes anywhere near mental health services, and once they come into mental health services, unfortunately, they are reproduced again and again and again.

Is there anything that we're doing well in psychiatry to address race equity?

Dr Mohan: The College is on a very long journey in terms of addressing issues to do with racial discrimination and discrimination in general. In 2020, when Dr Adrian James became the President of the Royal College of Psychiatry, he set in motion a series of actions which have all been summarized in the College's [Equality Action Plan](#). This contains a number of steps or areas where actions need to happen. The importance here is that it's not recommendations, but what will be done. Now the next task is seeing them through. It has to mean an organizational shift. People should come into mental health services knowing that they'll be treated without any form of discrimination.

How can we be more successful in addressing this issue than we have in the past?

Dr Mohan: The importance of this type of work is to always learn from what kind of work has happened in the past. All the previous recommendations have huge value for us, in terms of identifying why those things haven't happened; where the barriers have been.

One of the things is how people deny there is racism and discrimination within organizations. Even when you have a lot of data, people try and explain it away based on various excuses, but the most important thing is to accept that there are systemic differences, and differences in experiences of people. When you see data showing disparities or inequalities, shame is not the only emotion you should feel; you should feel a sense of urgency and wanting to do things in an appropriate way.

Are you aware of any intersectional approaches that are being used to address inequality and mental health?

Dr Mohan: Mental health has not been very good at looking at things using an intersectional lens. Psychiatry has a unique advantage. We're very person-centred and our approaches are individualized. We have the requisite skill to work with people of all protected characteristics. When you have high quality services staffed by people with skills to work with all groups of individuals, and designed in such a way that they meet the needs of all individuals, we're likely to do much better. We still have to refine what our intersectional approach should be; above and beyond, using a person-centred approach, and, for example, using shared decision making as a central principle in delivering care.



What is your advice for psychiatrists experiencing racial inequality?

Dr Smith: There are ways in which our society is structured that are seemingly invisible, so we don't notice that they're structured in a way that disadvantages certain groups of people. Full stop.

So, the thing that all psychiatrists should do, regardless of your background, is read up and understand about structural factors. One of the things we're hoping to do is build into the curriculum ways people can learn about social determinants and structural factors and how they can impact mental health and mental health outcomes.

Oftentimes, people will put up with something for years and years and years and not know how to call it out, because they don't feel that there is a safe place to do that. Organizations need to develop safe structures and a safe process so people can report experiences of racism. In addition, if you don't feel comfortable calling it out in your workplace, then you need to go somewhere else to get support with that. One of the things we're hoping to do is develop some guidance around managing racism in the workforce for psychiatry. There's more and more being done. It's going to take a while. Supposedly there's been zero tolerance to racism and discrimination for years in the NHS, but we know that actually people suffer in silence. Don't suffer in silence anymore.

What can we all do to support this important agenda in our own areas of work?

Dr Mohan: The most important things everyone can do is, informing yourself, educating yourself and always thinking about the reasons why there are differences in clinical contacts, experiences, and outcomes, for different people that you see.

Do we really have the skills to understand, for example, what racial trauma actually can do to people? We haven't got that far with research, but there is very good evidence emerging about the impact of racial discrimination on physiological factors for mental health.

Then there is this concept of "minority stress". Being lesbian, gay or transgender means that you're going through so many more adverse life events throughout the lifespan, and then you present with depression, anxiety or suicidality in the end.

So, it is about the competence that you have as individual clinicians to pick up those factors that are not readily given to you on a plate. The structural inequalities that they have experienced throughout their lives. This is called structural competency; you want every clinician to

be structurally competent, and I'll give you an example why: if you have somebody in hospital and you want to discharge them, the factor that limits where they go is housing and the support they're likely or unlikely to get. It's nothing to do with the stage of recovery or medication you're giving. So, it's about understanding those things and not letting that be an afterthought. This is where you go beyond being an individual clinician and have to take on a small bit of activism, and this is about bringing about change. I would encourage people who have an interest to do that and to spread the message, because there aren't enough out there doing this type of work.

Any final words?

Dr Mohan: We need to think about the curriculum and make it fit for purpose. It has to suit the populations we serve. We can learn a lot about chromosome deletions and things like that, and I have nothing against neuroscience at all, but unless it's woven very carefully within the social fabric of where people exist, it doesn't really make a big difference to people.

Dr Smith: All the evidence is that social factors drive outcomes significantly. There isn't enough focus on the social determinants, given that we know that the majority of mental health problems are driven by social factors. We need to try and change the emphasis, so that there is more recognition of those social factors, so that all psychiatrists, and in fact all doctors, in their everyday work, take those into account as standard.

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Lessons from The White Panther Party

By Dr Alice DeBelle

As a psychiatry trainee practising after the death of George Floyd, I have found the response from the College, my seniors and colleagues enriching and reassuring. The issues raised are not new. In fact, they are depressingly familiar. We have been reminding ourselves that, after decades of reports on inequalities and lack of change, the time for talking is over. Decisive action is needed.

Whilst acknowledging that action is necessary for change, meaningful change is unlikely to materialise until a process of personal reflection is undertaken. From experienced clinicians, I have heard brave and honest admissions of ignorance, accompanied by an open willingness to learn. But as I look to my seniors for leadership, it has become apparent to me that some are further along this process of self-reflection than others. Some appear reluctant to relinquish the professional prestige that the medical perspective affords. There is a resistance to embracing a humbling position of 'not knowing'. This presents an opportunity for bi-directional learning between trainee and trainer. A new generation of trainees are starting to become intolerant of the status quo and are increasingly emboldened, holding their role models to account.

For example, at my place of work, there are now regular reflective and taught sessions, exploring the racialised context within which we practice. These are organised by an excellent, newly formed group, founded by trainees. The events are attended by a cross section of senior and junior staff and academics. We learn and reflect together and as equals. In addition, amongst several successful collaborative events, one deserves a mention. It was an important and thoughtfully curated day to mark the 10th anniversary of the death of Olaseni Lewis. He was an inpatient who died in the presence of a psychiatrist, whilst being restrained by the police in a psychiatric hospital. All psychiatrists should know about his death. Seni Lewis' mother and the mother of Sean Rigg were at the event, and they spoke like true leaders. I don't think I will ever forget that day.

However, there have been times since the death of George Floyd where I have felt let down and disappointed by my profession. Some senior figures do not appear meaningfully engaged in the discourse going on all around them. Other trainees and I, as well as many supportive seniors, have become increasingly concerned with the notion of 'excited delirium' (also known as 'acute behavioural disturbance') gaining traction in the UK. Following the death of George Floyd, there was a recent

publication in an RCPsych journal which sought to legitimise this term. The authors made a case that 'acute behavioural disturbance' constitutes a 'medical emergency', knowledge of which could save lives [1]. Whilst the intention may be to protect patients, the impact of these terms gaining any further credence cannot be underestimated, not only within psychiatry but across medicine and law. The terms offer a highly dubious but convenient biological explanation as to why fatalities occur following police restraint, devoid of the obvious racialised context. These terms constitute a major step backwards in any progress towards racial equality in health.

The notion that this concept could protect patients is flawed. The evidence suggests the legitimisation of 'excited delirium' could increase the use of forceful restraint and cause deaths, rather than prevent them. In the largest review to date, there is evidence that diagnoses of 'excited delirium' have resulted in fatalities following 'aggressive forms of police restraint' [2]. This term was used by the police officers during their restraints of George Floyd [3] and Elijah McClain [4].

This issue presents an opportunity for the bi-directional learning I referred to. I and others look forward to engaging with those that are under the impression that the terms 'excited delirium' and 'acute behavioural disturbance' are benign.

So, what next?

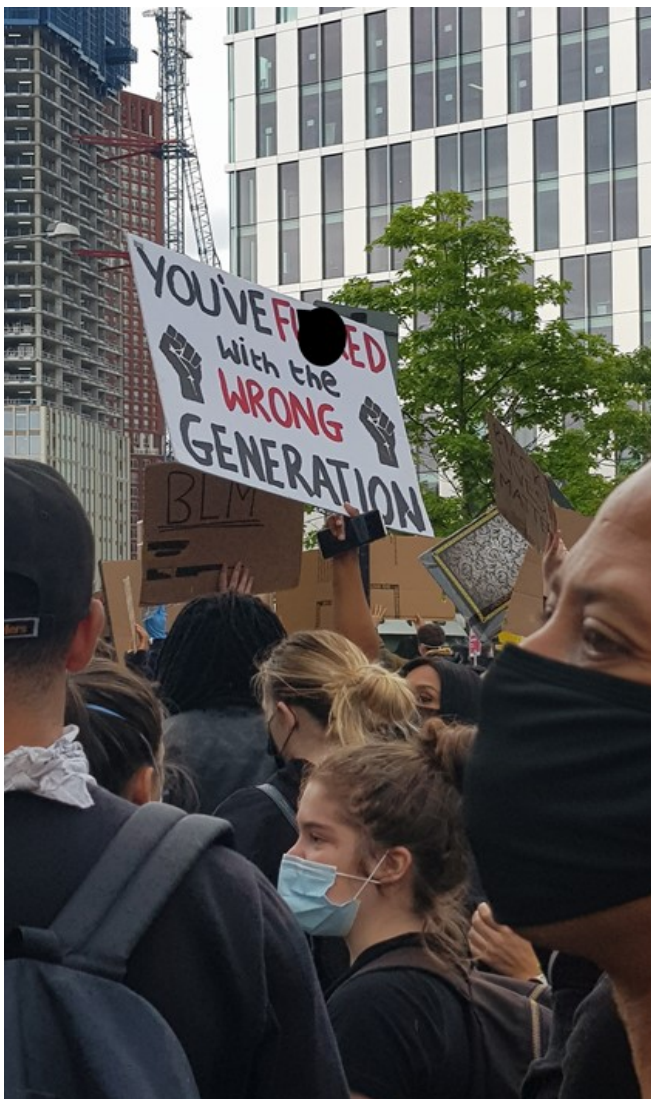
Emma Dabiri's critique of the term 'white ally' is compelling. She advocates a move away from ally-ship, towards coalition [5]. The definition of ally is: 'someone who helps and supports someone else'. I don't want to 'help and support' Black people out of the goodness of my heart; as an act of charity or saviourism. Frankly, I'm trying to help myself. I'm trying to find a reason to continue in psychiatry, where, even after George Floyd, racial ignorance is often tolerated, perpetuated or even show-cased.

When the co-founder of the Black Panther Party Huey P. Newton was asked what white people could do to help the cause, he said; 'they should start a White Panther Party'. The White Panther Party was formed, and their manifesto was remarkably similar to the Black Panther's. For example, they demanded 'power for all people to determine their own destinies' and 'justice' [5].



In my view, white psychiatry trainees should not seek to become 'allies' with their Black colleagues. Instead, we should form coalitions, as equals, across levels of seniority, across all shades of skin colour, discipline, and so forth. We are all stakeholders in this; we have some major common interests, and we all are set to gain from change. The definition of coalition is: 'a group of people working together to achieve something'. This feels far more representative of what I'm striving for than 'ally-ship'.

If, as a trainee (or trainer), you want to progress the practice of psychiatry and improve its reputation, if you want to protect and improve the quality of the scientific literature, if you want to trust the textbooks you read, if you take pride in making a true difference to the lives of your patients, and if you are for justice and fairness and truth, then start forming coalitions.



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Inequalities faced by Irish Travellers

By Dr Vaishnavi Sornarajah

End consultation, provide patient information leaflet. This act has been drummed into me since medical school, over and over. So I did. I passed a leaflet over in exchange for his signed consent form which had the two letters of his initials in a carefully calculated hesitant script. A beat, my heart sank. I realised that I had assumed he could read.

Assumptions such as these are often built into systems, forming barriers for access to care for certain groups. We all know that navigating the labyrinth of the National Health Service is hard. But what if you couldn't read or there aren't any resources for you?

The Traveller community face these obstacles, as well as explicit racism and unconscious bias.

Travellers are a nomadic ethnic group with Irish roots and number approximately 60,000 as per the 2011 census, however the true number is estimated at 300,000 (1). The census also found that more than half of Travellers live in permanent accommodation. Despite this, much of the public discourse surrounding the Travelling community centres on conflicts between Travellers and landowners. The police and council are often involved in moving groups from sites, leading to distrust in public authorities. Often these same organisations are responsible for providing care, education, infrastructure and health. This fuels a cycle of mistrust between marginalized Traveller communities and public bodies who provide services but view Travellers with suspicion. The unfortunate result is that Travellers experience some of the worst outcomes in education and health. Public bodies, in turn, lack an understanding of this community and fail to count them in their data.

Data Gaps

This absence of data results in data gaps. Data gaps occur when information on particular groups is lacking in databases that are used to commission services. Many public bodies do not have an option for Travellers to disclose ethnicity. For example, the [NHS data dictionary](#), which provides a reference point for information standards across NHS England, does not have a code to capture Irish Travellers (1).

This is a serious problem because Traveller communities have unique needs that are not being taken into account by public services. It leads to a lack of necessary infrastructure such as clean pitch sites and an inability to accommodate specific education and health needs.

Education

The gap is particularly large with education. Despite the right of Traveller children to be educated being enshrined by the Human Rights Act, too many Traveller children leave school before 16. I saw this first hand whilst doing Child and Adolescent Psychiatry. Despite being 15, my patient had not been to school in over three years. Her school refusal did not raise alarm bells in either the school or council. By not going to school, my patient had become more isolated from her peers and wider society.

This is a scenario that is often repeated across the country with Travellers leaving school at a much younger age or being classed as persistently absent (1).

These school absences are in part due to protracted bullying and indifferent establishments. Travellers face the use of racial slurs at school and teachers with low expectations, resulting in parents taking their children out of school. A lack of school attendance leads to poor outcomes in all areas, especially literacy as shown in Figure 2 (1).

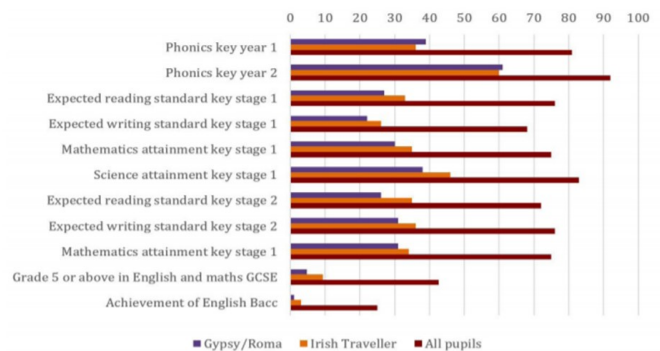


Figure 2: Attainment of qualifications for Irish Travellers and Gypsy/Roma compared to all pupils

Health

A lack of literacy cements inequalities especially in healthcare. How would you read letters for appointments? Or understand leaflets given by clumsy SHOs?

Other barriers faced include the lack of a permanent address which leads to difficulties in accessing GPs. Without GPs there is no access to secondary services, immunisations, maternity services and more.



Navigating the complexities of the NHS and a fragmented response to the needs of Travellers causes distrust in services and further disengagement. Travellers are less likely to be satisfied with the service from healthcare providers (75.6% satisfaction compared to 86.2% for white British) (1).

The result is that individuals in the Traveller community have a life expectancy 10 to 12 years less and a suicide rate 6 to 7 times higher than that of the general population (2).

The Traveller community are also overrepresented in forensic psychiatric hospitals in Ireland, accounting for 3.4% of admissions despite being 0.38% of the adult population (2).

These poor outcomes are likely due to the stigma associated with mental health in the community but are further compounded by the difficulties in accessing care.

Future Prospects

How do we improve these outcomes and improve the relationship between services and the Travelling community?

The first step is building trust. Quite often it has been left to individuals to build and maintain relationships with communities. It is now acknowledged that this is not a long-term solution and that public bodies require proactive policies of engagement (3).

For example, one trust in the Republic of Ireland employed a Traveller Mental Health Liaison Nurse who worked specifically with the community within a mental health team. This intervention was regarded positively within the community and led to increased engagement with services (3).

Secondly, there needs to be significant improvements in data collection. We cannot start to fix the problem if we do not know the scale of the problem.

Another improvement would be the issuing of literacy cards throughout the NHS. These would act as prompts to staff to provide substitutes to written information and help with forms (4).

Following these would be a great step forward in reducing the health inequalities experienced by the Traveller community.

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My journey as a Psychiatrist: From an International Medical Graduate (IMG) to a Compassionate Psychiatrist

By Dr Shobha Puttaswamaiah

Covid, disparity and mental health

Never before has there been as much focus on mental health and wellbeing as now, since the Covid-19 pandemic. We are all facing the impact on our mental health with new ways of working and living, apart from the most obvious of all, the fear of succumbing to the virus itself. With so many aspects of our lives thrown out of our control, managing our mental health has certainly become more important. Those of us who are International Medical Graduates (IMGs) and from Black and Minority Ethnic background have the additional burden of higher risk of mortality from Covid-19 alongside the social isolation and its consequences on mental health.

As psychiatrists, we would like to believe that we are the specialists, and we are in a better state of mental health than the rest of the population. If we are true to ourselves; are we really able to achieve a state of health as defined by the WHO ("a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity") at all times? The last year has been a testament to our resilience as a speciality and a litmus test to see if we can manage ourselves as individuals, in spite of what the outside situation may bring. At an organisation level, staff wellbeing has been taken seriously by the NHS and a lot has been done over the last year to support staff in various ways during this pandemic. It is humbling to see that we are able to recognise that, as a speciality, we are not immune to the effects of stress and burnout. During these times of increasing demands on our services, it is even more important we look after our wellbeing and each other.

Early days as an IMG, serendipity

My early days as an IMG trainee in this country were certainly not smooth. After all the hurdles I had to go through to arrive in the UK to train as a psychiatrist, I found myself facing many challenges one after the other. This was certainly not what I was hoping my life would be in the UK. The effects of migration, social isolation, discrimination, lack of social support, pressures of juggling family, professional commitments and exams cannot be underestimated. These experiences certainly helped me connect with the struggles of my patients, and to become more aware of my own inner self. It also made me aware of my own vulnerabilities and that I needed to do something to build my own inner resilience. This was a turning point for me to look within and start my journey towards my own growth and wellbeing. I started exploring a few new

avenues to achieve this and tried a few meditation techniques. But they did not seem to resonate with me. I soon found myself registering for a wellbeing course. This has certainly been the most positive step I have taken for my own wellbeing. I learnt certain Yoga and Meditation techniques during the program which equipped me to re-engineer myself and enhance my general wellbeing (1). The sense of freedom and ease I experienced after the program was something completely unexpected. Since then, my everyday routine of yoga and meditation has been helping me beyond words both personally and professionally. During this difficult period of Covid-19, these practices are certainly helping me to stay resilient physically and mentally.

Yoga, meditation and current evidence

Having experienced the benefits of the practices, I became more open to explore the scientific basis for the effects of Yoga and Meditation on our physical and mental wellbeing. There is plenty of evidence to demonstrate the physiological and neurochemical responses yoga and meditation practices can produce on the body and mind (2). It is fascinating to understand how some simple practices can cause both structural and functional effects on brain regions and brain circuits (3). Certain practices can enhance neurogenesis through its effect on Brain Derived Neurotrophic Factor (BDNF), lead to positive states of psychological wellbeing by increasing blood levels of endocannabinoids (called anandamide, in Sanskrit means bliss) and through counteracting the stress response (4).

Holistic care - the way forward

The GMC workforce report 2019 recognises that wellbeing is key to improving retention of doctors and quality of patient care (5). It becomes even more prudent at times like these, that as psychiatrists we invest in enhancing ourselves and our inner resilience. This will no doubt benefit us but also the care we provide to our patients. It is also time we incorporate a more holistic model of care in both prevention and management.

Self-transformation

My early days as an IMG were no doubt challenging but certainly shaped my evolution as a psychiatrist. While it made me more self-aware, the yoga and meditation practices helped me become more grounded and resilient. I am grateful for this journey which has led me to discover myself and my own self-transformation.



It has certainly helped me continue to evolve to be a more compassionate psychiatrist and a better human being.

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Culture Vulture: ‘Salieri, Copperfield and Miss Moneypenny: bringing racial equality to performing arts’

By Dr Emmeline Lagunes-Cordoba

When Lawrence Olivier went ‘Blackface’ to portray Othello in 1965, he was not only praised for his role, he even received an Oscar nomination for his performance in the classic Shakespeare tragedy. Similarly, through cinema history, many other white actors have been cast as people from other ethnic backgrounds and received praise even if they altered or exaggerate physical features to look “less white”. Although this practice has rightly reduced over the last few years, when actors from Black, Asian and Minority Ethnic backgrounds have played ‘white’ roles, criticism has also arisen, even if the role had not been written with a skin colour description. When Noma Dumezweni, a Black actor of South African background was cast as the ‘Harry Potter’ protagonist Hermione Granger, there was criticism and even anger from some people who disputed that this character could be played perfectly well by a non-white actor.

As a psychiatrist, and as an international graduate born and trained in Mexico, I identify as an ethnic minority in the UK, and struggle with the idea of not been allowed to work in a role purely based on my skin colour or ethnic background; to have my knowledge and expertise not recognised by something I have no control over. However, in real life many people still face limitations and reduced opportunities for having the “wrong” physical characteristics, and this is especially evident, and apparently “acceptable”, within the performing arts. Positively, there has been some change, with more producers and directors casting actors from different background to play iconic roles which before were only offered to white performers. More actors are now hired on the basis of their capacity to portray emotions – to act! - rather than by their non-talent related colour of their skin. This has not only opened up opportunities for more Black, Asian and Minority Ethnic actors, it has also left the audience with some iconic performances which have transcended characters, making us forget it is an actor the one we are watching, and not a real person living in another space and time.

Who can detach the Avengers’ character Nick Fury from actor Samuel L. Jackson, or who can imagine someone else rather than Morgan Freeman playing the kind and thoughtful Red in the Shawshank Redemption. These two characters were conceived as white men by their creators but brought to life by two very talented actors who were given the opportunity to do their jobs because of their capacity and not because of the way they look. Also, recent portrayals of classic books and plays’ characters

performed by actors from Black, Asian and Minority Ethnic background have confirmed there is not a need to hire someone from a given ethnicity to be immersed in a story, to understand a character’s feeling and motivations, to be moved, to be entertained, and forget about our worries for a while.

Four years ago, Lucian Msamati played Salieri at the classic Amadeus play. His performance was not only praised by the public and critics, he also showed us we are capable of looking beyond someone’s skin colour and put attention to the things that matter, to the person in front of us, their feelings, their virtues and their pain. Last year Dev Patel played Charles Dickens’ David Copperfield in the eponymous film. There, Patel was able to give life to a very realistic David Copperfield, his anguish, his hope, his learning and his joy after finally finding love with his beloved Agnes, also beautifully portrayed by Rosalind Eleazar, another actor from a Black, Asian and Minority Ethnic background. In the latest James Bond films, Naomie Harris played Miss Moneypenny, one of the few constant females in the James Bond universe; in her version, Naomie Harris managed to create a bolder and more exciting Miss Moneypenny, which helped give this character a much needed update more in tune with our current era.

As psychiatrists, we might not face the same restrictions many performing artists still face based on their skin colour or ethnic background. We know our ability to work or have a career within the NHS is not constrained by these characteristics; we can proudly say the NHS is one of the most diverse employers within the NHS. However, within the NHS we still face the “snowy white peaks”, as senior roles, including Trust Boards, are still dominated by white staff, with some Trusts completely lacking Black, Asian and Minority Ethnic staff among their executive and non-executive members (Kline 2014). We can question if ‘traditionally white roles’ are being preferentially given to white staff, or what conscious and subconscious biases and barriers are stopping roles being offered to people from Black, Asian and Minority Ethnic backgrounds, even if the skin colour for these roles was not described in Kline’s book.

Ensuring equality among doctors and other NHS staff should not be that different to ensuring equality within the performing arts. We need to remember that a person’s capacity to perform and excel in their duties is not linked to their ethnic background or their physical appearance.



So, as with current film and theatre producers and directors, NHS board members need to start casting more staff from Black, Asian and Minority Ethnic backgrounds for their leading roles; for them to have the opportunity of give outstanding and unforgettable performances that can show people that the limit is on the institutions and not on its people. Now, let's wait to see what happens first- the first ever Black, Asian and Minority Ethnic background James Bond (did somebody say Idris Elba?) or the first ever Chief Executive of NHS England from a Black, Asian and Minority Ethnic background. I suspect it will be the former, but let's hope this time the NHS will win this race.



I recognise that "BAME" is not a term endorsed by all, but it remains perhaps the most commonly used one in healthcare. I also recognise the many levels of intersectionality that can impact bias and prejudice, both within the performing arts and within healthcare organisations: from skin tone, through gender, to sexual orientation: I acknowledge that all journeys are unique, and many will have had different experiences. However, our goal should be the same, to ensure racial equality, within our jobs, our art and our lives. Art is a natural expression of our humanity which should be encouraged, shared and celebrated; not limited, coerced or rationed by unfair social boundaries based on purely gene expression.



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Where are our anti-racist curricula?

By Dr Funmi Deinde

Whether it is microaggressions, bias, discrimination, racial profiling or stereotyping, it is all racism and causes the same trauma. Medical students and doctors should be taught a curriculum which is informed by and addresses the needs of our diverse multicultural and multiracial society.

Different racial groups face different societal and individual challenges, and so will have experiences of mental health problems which specifically reflect their culture and context¹. This is why group labels such as "Black, Asian, and Minority Ethnic", which can be helpful in some contexts, mostly does a disservice to its members by making it seem as if we are just one homogenous group with identical lived experiences, which is simply not true. Black people can be subjected to anti-Black racism from other non-Black ethnic minority groups, not only from white people. Anti-Black stereotypes, colonial falsehoods (e.g. the inferiority and primitiveness of the African) and the need for Black ethnic groups to assimilate into the dominant white society have all been put forth as reasons for this. Additionally, the model minority myth has frequently been used as a means to belittle Black people.

Psychologist Guilaine Kinouani states 'within the system we have inherited: white supremacy, human lives in our society are stratified and our life experiences and opportunities are still dependant on our racial backgrounds'.¹ Writer Natalie Morris simplifies this by stating 'our racial hierarchy places white people at the top and places Black people at the bottom – non-Black people of colour stand somewhere in-between'.¹ This is not to say that other minority groups have not faced significant racism, but rather to highlight that Black people can be disproportionately affected by specific types of racial discrimination due to our position within this racial hierarchy.

Post Traumatic Slave Syndrome (PTSS) is the assertion that Black people globally have suffered collective grief and trauma over generations.² Being acutely aware of this, along with receiving 'the talk' from our parents (as their parents before provided them, and so on) on how to navigate and survive in a society that seems to value Black lives very little, if at all, can make the world for Black people appear hostile and threatening, leading some of us to be in a constant mode of survival. It therefore comes as no surprise that research suggests being subjected to racism can be very damaging to the mental health of an individual.³ Various studies have demonstrated the consequences of racism to include psychological and

emotional distress, post-traumatic stress disorder, depression, anxiety, obsessive-compulsive symptoms, chronic stress, and somatisation.⁴

I work within a specialty where Black people are overrepresented as patients, are more likely to be given psychotropic medication as opposed to psychological therapies, are more likely to be admitted to hospital under section, and are more likely to be given psychosis as a diagnosis.^{2,3} I often wonder how many mental health professionals take the time to educate themselves and reflect on possible reasons for the above, or consider how the individual's lived experience may have contributed to their presentation.

On a number of occasions, I have seen patient clerkings for Black males where they have been described as 'Afro Caribbean' in the mental state examination despite the history clearly stating the African country from which they hail from. Some may dismiss this as inconsequential, but I can assure you that it is not. Not only is this patently incorrect, but it is indicative of the tendency for Black people as a whole to be dehumanised and treated as a monolith, which is highly problematic as it means that the individual's unique story, background and experiences are not considered with any nuance or thoughtfulness, which can lead to poor care.

Not many people are aware of the horrific history of medical experimentation on Black people such as the Tuskegee Syphilis Experiment, or Dr John Sims' gynaecological experiments on Black female slaves. This legacy can affect the degree of trust Black people have in the health care system, and understandably so.

If psychiatrists and psychologists, the majority of whom are not Black, are unaware of, or unwilling to educate themselves on, these matters, then they are failing to provide their Black patients with holistic patient centred care, as they are not taking into account the impact of their patients' racialised experiences upon their mental health.

Despite all of the above, the Royal College of Psychiatrists (RCPsych) curricula⁵ have no specific learning objectives related to lived experiences, anti-racist mental health care, anti-Black racism, or racial and ancestral trauma, which is rather concerning. As mental health professionals, we hold a lot of power; the trajectory of a human being's life can be significantly affected by the decisions we make. Even death can be an outcome, evidenced by the cases of David Bennett and Seni Lewis.



Since the stakes are this high, why is it that our curricula are woefully lacking in this area?

The RCPsych Equality Action Plan aims to review the core and higher training curricula 'to ensure they adequately reflect the knowledge and skills required to deliver clinical care that is equitable for all, including understanding the impact of structural inequalities and power differentials within mental health.' I do hope this leads to thoughtful and substantial changes which fully address the relationship between race and mental health.

A recent Lancet article⁴ presented guidelines for providing anti-racist mental health care, which I would encourage everyone to put into practice.

Finally, JM Cénat states that anti-racist mental health care 'can help improve human interactions between...mental health professionals and Black patients...help eliminate mistrust and fear of professionals, health-care systems and of care itself...help establish equity in care by reducing disparities, building confidence in care systems, humanising care and restoring hope to people from Black communities. Psychiatrists, psychologists, social workers and nurses working in mental health must recognise that it will never be enough to be non-racist; they must commit themselves to be anti-racist towards care that facilitates social justice, rather than endorsing a racist and dehumanised system.'⁴ I completely agree.

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Why might ethnicity affect outcomes in postgraduate medical exams?

By Christopher Travers, Dr Samantha Perera, Dr Dan Cleall

This month, our book "The Maudsley Trainee Guide to the CASC: Preparing for the MRCPsych CASC Examination" will be published after years of tireless labour. We were driven to create this preparatory guide by a lack of suitable existent materials, and a desire to address what we perceived as disparities in exam outcomes: for UK-graduate trainees from ethnic minority backgrounds, for international graduate trainees, for those in smaller or remote training programmes, and for those who are less well off and therefore not as likely to access expensive training courses.

Readers may be forgiven for dismissing recent figures from the General Medical Council (GMC), which show on average 49.2% of CASC candidates who are International Medical Graduates (defined by the GMC as any candidate that studied outside the UK and European Economic Area) passed the CASC in 2019, compared to 92.2% of UK graduates.¹ Some innocent factors could reasonably predict such a disparity: UK exams should be expected to correspond more closely with UK medical school curricula. But such a wide margin of disparity could obscure whether ethnicity might be independently playing a role. Unfortunately, a breakdown of pass rates by ethnic group is not currently publicly available for the CASC exam in isolation; however, across all RCPsych examinations in 2019, white graduates of UK medical schools were 15.7% more likely to pass than Black, Asian and Minority Ethnic graduates of UK [medical schools](#).¹ Again, these are all graduates of UK medical schools, separated by ethnicity alone. This, we would hope, is more straightforwardly alarming to readers, and in our view it is shockingly under-discussed. Disappointingly, this is not by any means new information; such significant discrepancies in Royal College clinical examination pass rates have been well documented across many specialties over several years, and in fact has previously resulted in a legal challenge.

In 2014, the British Association of Physicians of Indian Origin (BAPIO) sought to challenge, via legal review the Royal College of General Practitioners' Clinical Skills Assessment (CSA).² BAPIO, as claimant, argued that the low pass rates of South Asian, Black, and Minority Ethnic doctors reflected discrimination, whether directly or indirectly, and therefore that the examination itself was unlawful per the Equality Act 2010. The defendants were the Royal College of General Practitioners (RCGP), as those who carry out the examination; and the GMC, as the body responsible for its regulation. The High Court did not find that the examination was straightforwardly unlawful, but

Justice Mitting noted in his judgment that unless existent wide-ranging recommendations from investigations on the matter were implemented by RCGP in a timely manner, they might be found in breach of the law by a subsequent judicial review (which has not yet been brought). Justice Mitting referenced several reports, including one commissioned by the GMC in 2013 and written by Professors [Aneez Esmail and Chris Roberts](#).³ This report made wide-ranging recommendations including, but not limited to, the following:

- That the RCGP should make IMG candidates aware of differential pass rates;
- That the RCGP should make specific provisions for IMG candidates;
- That the RCGP should endeavour to provide a less ethnically narrow range of examiners and mock-patients;
- That formative feedback to candidates should clearly describe any weaknesses and how to address these, and
- That the GMC should commission further research into whether examiners' scoring differs when applied to candidates whose ethnicities differ from their own.

The outcomes which provoked the legal challenge were not unique to the RCGP, and as such the legal judgment in 2014 had clear ramifications for other Royal Colleges, including RCPsych. Practically speaking, it is of course almost impossible to assess meaningfully the individual impact of deficits against these specific recommendations: to what extent would correcting these flaws address the attainment gaps? Yet, these common sense recommendations, in practice, stand already for all Royal Colleges. What progress has each College made so far against these recommendations?

The RCPsych supported us in drawing attention to these shocking statistics in our book, and we are pleased that this specific issue, and efforts in line with the recommendations discussed above, are publicly and specifically addressed in the [RCPsych Equality Action Plan published in January 2021](#).⁴ We are particularly grateful for the generous advice and help of Professor Aneez Esmail, Professor Subodh Dave (RCPsych Dean-elect) and Dr Shubulade Smith CBE (RCPsych Presidential Lead for Race Equality). We hope that our collaboration will help in the College's urgent attempts to address the unsatisfactory status quo.



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Racism and Race Trauma

By Dr Amit Mukherjee

As a part of the Black History Month last year, a talk was organised called, "Understanding and Working with Racism and Racial Trauma." It was hosted by Dr Roberta Babb, a Registered and Chartered Highly Specialist Clinical Psychologist and Registered Forensic Psychodynamic Psychotherapist. This talk provided an understanding of how racism and its components impact marginalised and oppressed individuals, contributing to the development and experience of race-based distress/stress and racial trauma.

Often missed or overlooked by mental health professionals, race-based encounters produce distress and possibly mental health impairment or psychologically damaging trauma.

Racial discrimination can lead to hostility, direct or subtle, harassment or victimisation. Depending on individual resilience, health and other factors, a victim of racial discrimination may experience a range of symptoms such as depression, anxiety, acute stress reactions and trauma with symptoms of intrusion, avoidance, and arousal. One may express the trauma through anxiety, anger, rage, depression, low self-esteem, shame, and guilt. The current diagnostic system does not help individuals or mental health professionals recognise the racial aspects of the above diagnoses.

Development of Post Traumatic Stress Disorder occurs after exposure to an event (e.g. disasters, combat, and violence). Contemporary racial discrimination and racism rarely involves actual threat to life but race-based encounters can be variable (e.g. racial profiling, verbal assault, denied access or service, etc.) and even subtle in some cases. Race discrimination victims do not have a way to delineate or describe the encounter other than to name it as racism or discrimination. In addition, they are less able to report its emotional and psychological effects other than to say they were upset, angry, or depressed. Affirming a patient's possible harm or injury and racism as a potentially harmful experience, helps the patient to seek treatment and redress.

The use of the term, "race-based traumatic stress injury," in contrast, would mean that the person, depending on his interpretation of the encounter, would understand how the racial experience has contributed to or is related to psychiatric impairment. This would make it easier for some people to accept the impairment and to work towards healing.[1]

With such a term, people will be able to clearly identify what happens to them and will be able to recognise the encounter not simply as racism in the form of discrimination as generally used and defined. It will help them to recognise that claims of racism should be treated as valid and potentially harmful experiences that warrant redress.

Driven by the need to analyse how a particular type of racist act or race-based experience is related to a person's psychological reactions and its subsequent mental health effect and to incorporate race and cultural issues in clinical formulations and diagnoses, scales have been developed to measure race related stress and models of trauma. Some of these measure low self esteem, anger and even experiences of disassociation as a result of race-based trauma. [2]

For instance, in *Measuring the Effects of Racism*, Robert T. Carter and Alex L. Pieterse offer a manual for mental health professionals on how to understand, assess, and treat the effects of racism as a psychological injury.

The use of the scales could have the effect of increasing the use of counselling services by underrepresented minority groups who may avoid treatment for fear that therapists will not understand.

Further research should explore issues to minimize the possible effect of recall bias and whether specific race discrimination experiences lead to specific reactions (e.g. depression, intrusion, etc.) and if these encounters would also predict race-based traumatic stress reactions. These could then further evaluate different types and approaches to counselling interventions. [3]

Of interest, I came across the 'The Trauma Therapy' project run by the anti-racist charity, The Monitoring Group, which was established to specifically address the acute absence of trauma support for victims of racist violence in the UK whilst their cases were being investigated and prosecuted, and even later because the psychological damage often continues long after cases have been settled. The project states that challenges remain such as language barriers, as English may not be their first language; and many may fear that a White counsellor would not fully understand their experiences given that 99% of the crimes were perpetrated by White people. [4]



Oppressed individuals cannot heal within a system that continues to oppress them. Therefore, from a clinical perspective, decolonialising mental health and clinical practice is needed. Alongside, there is a need for mental health professionals to reflect upon and examine their own positionality, mind and behaviour with regard to personal understanding of anti-racism, so as to think about meaningful and inclusive ways of working. Racial awareness amongst mental health professionals would help to legitimise psychological reactions to experiences of racism.

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Culture Vulture: ‘Through the Looking Glass’

By Dr Rupal Dave

The Hospital. 24 Hours in A&E. GPs Behind Closed Doors. In a schedule of medical documentaries exploring physical healthcare settings, *Stacey Dooley: On the Psych Ward* (2020) offered an insightful view of the journey taken by patients admitted to inpatient psychiatric care. Broadcast in March 2020, the programme followed the investigative journalist over three weeks as she worked alongside staff and patients at Springfield Hospital. One year later, in a healthcare landscape dramatically altered by the Covid-19 Pandemic, Dooley returns to screens in *Stacey Dooley: Back on the Psych Ward* (2021). Filmed over six months, we see her revisit Springfield Hospital to highlight challenges that will be all-too-familiar to mental healthcare professionals reading this review.

Over the course of both documentaries, the viewer learns of both the staff and patient experience through the narratives of named individuals in various settings. Oisin, 28, is seen in the Place of Safety (PoS) Suite shortly after being escorted to the suite subject to Section 136 of the Mental Health Act (MHA). Kyle, 19, and his father are interviewed in the Lotus Suite, where patients in crisis can be admitted informally for up to 2 days. Glimpses of Rachelle browsing her Instagram page, and 70 year old Christine, joyfully singing Shirley Bassey numbers, remind us that each of these individuals has a unique story. Is it possible to do justice to each of these stories in 57 minutes? Has breadth been offered at the expense of depth?

Laura, 24, bravely shares her experiences from both the PoS Suite and at interview 3 months later, and it is this format that I found especially powerful. Staff interviews are similarly presented in this way, and in gathering Laura’s reflections, months after her acute illness, there is greater parity in interviewing those on ‘both sides of the glass’.

The dedication and professionalism of colleagues in mental healthcare is clear throughout the documentary and the programme excels at presenting difficult decisions around admission, discharge and risk management.

There is much to be praised in the first documentary and so it feels perhaps unfair to suggest that *Back on the Psych Ward* succeeds where *On the Psych Ward* fell down on occasions. Perhaps, at this point, this piece becomes less of a Review and more of an invitation for discussion. There were some occasions in last year’s documentary when I questioned the appropriateness of the Dooley’s

direct, short-lived, involvement in patient care. A scene showing a patient described by the presenter as “kicking off” did not, understandably, show the patient’s identity; however as a result it focused entirely on the presenter, giving a somewhat voyeuristic effect of Dooley and audience observing ‘a curiosity behind the glass’. The Dooley’s reflections on the patient’s beliefs (“it’s heartbreaking...(he’s) talking to slugs...bless his heart”) offered a somewhat sensationalist approach that I had hoped the programme would avoid. It is clear that Dooley is interested in people’s stories and she approaches each person with genuine warmth, however at times there are difficult questions that I felt required exploration in a safer space, including references to past trauma and perception of self.

According to media reviews and social media tags (#BacktothePsychWard, #StaceyDooley), *Back to the Psych Ward* was well-received by audiences. The documentary offers a rare glimpse of the challenges mental healthcare units faced during the pandemic, including the impact of social isolation and increasing demand on a stretched system. The programme presents the difficulties faced by people with existing severe and enduring mental illness at a time when the conversation in mental healthcare has perhaps been more focused on new feelings of low mood, worry and stress in the context of the pandemic.

There are incredible stories of courage and hope amidst uncertainty. Ali is empowered to take up ‘self-exposure’ therapy for OCD; Coral is discharged with Home Treatment Team follow up; and Chloe describes her recovery. We also meet remarkable staff members, bravely sharing honest and personal experiences of mental illness.

I have no doubt the documentary team followed all guidelines around informed consent. This included post-filming participation. Of note, *Back to the Psych Ward* featured follow-up accounts with all but one of the patients. It was sensitively edited and the extended filming scheduling was carefully considered. This meant that moments of particular vulnerability could be shared; however an area of debate might be whether such moments should have been - with particular reference to acute illness.

Sharief, a gentleman describing persecutory delusions, was interviewed the day after being admitted under Section 2 of the MHA.



I found myself wondering whether Sharief would have been filmed for a physical health documentary at a time when experiencing similarly severe physical health symptoms, for example during a myocardial infarction, an episode of delirium or immediately following a road traffic accident. Perhaps my opinion on this is overly paternalistic. I have come to see these moments, of vulnerability as private, fragile moments when patient dignity must be fiercely protected. There is a delicate balance in sharing this vulnerability, when aiming to reduce stigma and/or inform an audience.

Despite this, both *On the Psych Ward* and *Back to the Psych Ward* are important, thoughtfully-made documentaries. The fortitude of both patients and staff is highlighted, their stories are celebrated, and the makers successfully support the viewer to “See how hard it is. On both sides of the glass”.

References:

[1] Stacey Dooley: *On the Psych Ward* (2020) BBC One, Broadcast 19 February 2020

[2] Stacey Dooley: *Back on the Psych Ward* (2021) BBC Two, Broadcast 13 April 2021

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Poetry: Stir Crazy - Ode to a Lockdown Getaway

By Dr Anju Soni

*West n' racism is not limited to just the UK
The nurses have been left with just 1% increase in their pay
Let's leave the SARS COV2 lockdown for another day
Weekends are for horseplay
Today I'm off to Pompeii
On my sleigh
For a game of croquet
Hooray!!!*

*Friends are welcome to get themselves vaccinated and come away
Join me for a Summer's day
It doesn't matter whether it's Pfizer, Moderna, AstraZeneca or J&J
It goes without saying, vaccine
Is the best sunscreen
Robustly reducing hospitalization and horribly high death rates each day
As we continue to pray
Squabbling is not my way*

*Discriminate and incriminate
Cataclysmic secrets
Oppression and emancipation
In lockdown we get a taste of our own prescription
Maybe different tombstones
But we all share the same grave losing all but barebones*

*My rights should not be a minority priority
Alas! as a Homo sapien you don't always get an equal say
Lest we forget we are under the same sky, even if it's grey
We all see the same moon
Parity of esteem between mind and body malady
Consider that to be a boon
The poem never rose above banality
Your stethoscope makes me croon*

*Facts always triumph over fiction, whatever people might say
Masks are here to stay
Distracted by Brexit, sometimes we do not hear
The voices of those imperiously defeated by brain fog, fatigue and fear
The long COVID haulers seemingly submerged in a sunken submarine spray
Fortitude seeping away
Oxygen saturations are the most predictive of mortality and ICU stay
Even small changes in those with SARS COV2 are prey
Ending up in the sick bay
Nations that have done well*



*Don't allow low oxygen levels to tell
Let's learn the lesson. Be quick with care, don't delay
And don't forget to wash the COVID blues and germs away*

*Subject to a negative RT-PCR test
I should hopefully be there by midday in time to rest
Embrace social distancing as says the BMJ
Even after the South African variant leaves Ealing Broadway
It's not child's play
Let's not treat it like Ground hog Day
Where's my 1st jab?
More than 100 countries say
In this great universal array
Don't forget to bring your rays
If U don't agree, go and listen to Beyoncé!!!*

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Further information



Colourful-Minds is a non-profit mental health organisation that engages with local communities and beyond to educate about mental health in an effort to bridge the gap between mental health services and Black and minority ethnic communities.

www.colourful-minds.org.uk

Join us!

We're looking for a new member to join the Psychiatric Eye newsletter team!

Enthusiasm, creativity, and interest in writing and editing are vital.

Please send us an e-mail if you're interested in getting involved!

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Winning Article

Congratulations to Dr Ogunmuyiwa, Dr Das, Dr Polling and Dr Bhavsar for winning Best Article for the Spring 2021 Edition for their submission:

**'Are we listening?
Reflections on racial injustice in
Mental Health Services'**

Read all about it on page 3.

Disclaimer:

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