‘Scientific Racism’ and structural inequalities: Implications for researching Black mental health

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Black mental health in the UK

Ethnic inequalities in mental healthcare is one of the most consistent findings in UK research. Perhaps the most stubborn, is substantially elevated risk of diagnosis with schizophrenia and related psychoses among people of African and Caribbean descent (Black) compared with White British peers[1]. This difference is not replicated in findings from research in Africa[2] and the Caribbean[3], generating several theories to explain the racialised inequities in the UK. Hypotheses underpinned by biological (e.g. genetics), social (e.g. urbanicity or economic disadvantage), and psychological theories have been proposed yet none are conclusive. Intriguingly, Black people in England are significantly less likely to be diagnosed with neurotic disorders such as depression and anxiety, suggesting more nuanced approaches to understanding and addressing these disparities are needed[4].

Whilst the extent to which diagnostic rates reflect levels of morbidity versus psychiatric practice remains contested[5], what is unequivocal is that Black people experience inequalities at every level of the mental health system. Firstly, Black access to services is characterised by delayed diagnosis and negative care pathways[6, 7]. Compared with White British counterparts, Black people are four times as likely (306.8 per 100,000 versus 72.9 per 100,000) to be compulsorily admitted to psychiatric care under the Mental Health Act[8] and are less likely to receive GP support in accessing specialist mental healthcare[9]. As psychiatric inpatients, Black people experience more coercive care. For example, higher levels of treatment in seclusion, forcible injection with psychotropic medication, and being subject to control and restraint techniques[10, 11].

Disproportionate use of force with Black patients is associated with elevated death rates in psychiatric care. The 2004 Blofeld Report[12] into the death of David ‘Rocky’ Bennett six years earlier found that, the way in which he was restrained by nursing staff, resulted from his treatment as a “lesser being”. The then Secretary of State for Health, John Reid, asserted that there was “no place for discrimination in the NHS”, but did not commit to enacting any of Blofeld’s 22 recommendations to tackle the kind of racism that David Bennett experienced at the hands of both patients and staff. Subsequently, the Department of Health responded with a 5-year ‘Delivering Race Equality (DRE) in Mental Health’ policy guidance and action plan[13]. CQC’s findings[14] that DRE had improved little in Black patients’ psychiatric care is evidenced by the passing of Sani’s Law[15] in 2018 after Olaseni ‘Seni’ Lewis’ death due to being forcibly restrained by 11 police officers in psychiatric hospital. Alongside greater exposure to coercive care, Black people are also less likely to be offered evidence-based

psychological care. This begs the question of why ethnic inequalities persist despite policies and legislation to eradicate them within a system designed and commissioned to deliver care equitably - a principle enshrined in the Public Sector Equality Duty under the Equality Act 2010[16].

Scientific racism and contemporary mental healthcare

Exploring the historical relationship between psychiatry, psychology, and 'race science' might provide a lens through which to view Black people's sub-optimal access, experiences and outcomes in contemporary mental health care. Although now generally agreed to be a social construct[17, 18], the biological basis of 'race' and theories purporting racial hierarchies have informed explanations of different groups' location in society. In his treatise, *'Crania Americana',* 19th century American anthropologist and physician, Samuel George Morton, concluded that the Caucasian's place at the top of the racial hierarchy resulted from superior mental capacity to other 'races' as evidenced by having larger skulls to accommodate larger brains. Superior intelligence coupled with advanced planning skills, self-control and longevity were said to distinguish Caucasians, and indeed all other 'races', from Africans[19]. Impulsive, superstitious and prone to violence by nature, 'Negroes' (the "lowest grade of humanity" and ranked just above primates) were deemed incapable of creativity; merely able to imitate others and manage routine work under supervision[20]. Thus, 'race science' was used to justify the enslavement of Africans and advance theories about how to manage them. In 1851, Samuel Cartwright proposed a new diagnosis, 'drapetomania', defining slaves' tendency to run away as a form of madness. The 'condition' still appeared in a medical dictionary almost 100 years later[21].

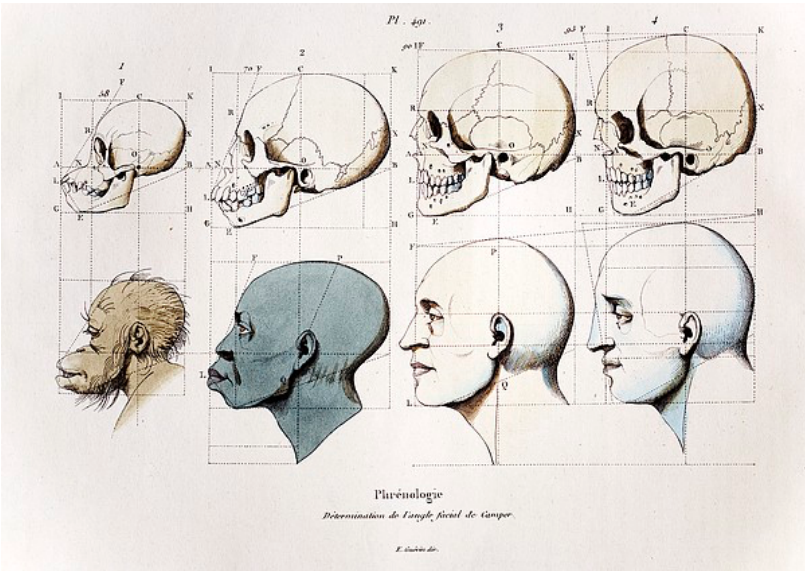

Figure 1. Shapes and sizes of various skulls

Stewart PT. 1760a Petrus Camper Facial Angle Eugenics [Internet] [cited 21 December 2020]. Available from: https://www.sciencephoto.com/media/152171/view/1760a-petrus-camper-facial-angle-eugenics

Psychologist Richard Herrnstein and political scientist Charles Murray's controversial book *'The Bell Curve: Intelligence and Class Structure in American Life*'[22] claimed that the

inequalities experienced by African Americans was due to having average IQs 15 points lower than that of White Americans. That being the case, they argued that individual differences and genetic predispositions rather than structural inequalities accounted for White people's ascendancy in a meritocratic system[23]. Leading psychologists, including Professor Hans Eysenck of University College London, publicly endorsed the authors' views that IQ tests measured true racial differences rather than access to education and that concerns about the cross-cultural validity of these tests were unfounded[24]. This is significant because, at his death in 1997, Eysenck was the world's most widely-cited and therefore influential academic psychologist. This line of argument has important socio-political implications as it suggests that there is little merit in improving the education of Black people or establishing initiatives designed to create a more level playing field.

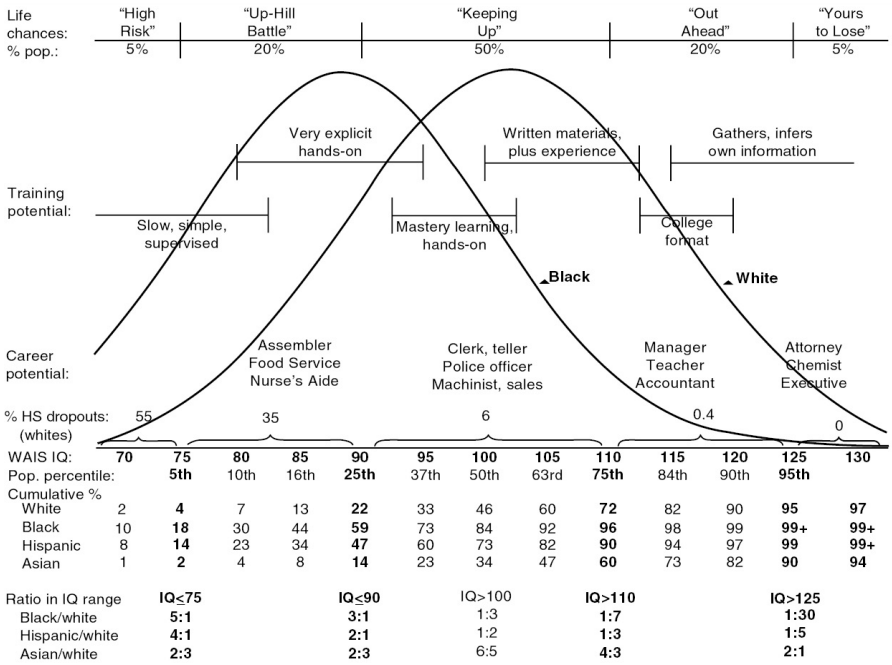

Figure 2: IQ Scores and 'the Bell Curve'

Gottfredson LS. G Theory [Internet]. 2018 [cited 21 December 2020]. Available from: https://www.cambridge.org/core/books/nature-of-human-intelligence/g-theory/E92EE6DB36A2D11DBF8B6C42F9940E00

Another signatory to the article in support of The Bell Curve's thesis was Professor Richard Lynn whose work was cited in the book. A member of the editorial board of the academic journal '*Personality and Individual Differences'* (PAID) until 2019, Lynn theorised links between race-based differences in intelligence[25] and psychopathic personality disorders[26]. In 2020, a paper published in PAID in 2012 claiming that genetic differences related to darkness of skin colour explained purported racial differences in sexual behaviour and violence, was retracted by publisher Elsiver[27]. Given that much of the 'evidence' on which the paper was based had been previously challenged, the decision to withdraw the paper in the wake of academic and research institutions' public statements on institutional racism is noteworthy.

The extent to which such views continue to inform contemporary mental health services, is illustrated by Black patients and Approved Mental Health Professionals' evidence to the 2018 Independent Review of the Mental Health Act[28], which was established in response to what

the then Prime Minister, Theresa May, described as the “burning injustice" of exponential rates of ‘sectioning’ under The Act. Since the Royal College of Psychiatrists acknowledged that psychiatry is institutionally racism in 2018, it has come under increasing pressure from its membership to do more to eradicate race-based disparities. In an open letter[29] to their newly elected President, 175 psychiatrists condemned the profession’s history of systematic racism and discrimination – specifically, of: i) ignoring the effects of discrimination on patients’ mental health, ii) painting other cultures as ‘psychologically primitive’, and iii) colluding in silencing civil rights protesters and political dissidents by labelling them ‘psychotic’. Jonathan Metzel’s *‘The Protest Psychosis: How schizophrenia became a Black* disease’[30] highlighted how schizophrenia, regarded as a ‘serious and enduring’ form of mental illness, became a racialised diagnosis inextricably linked with blackness and dangerousness. It is astonishing that, in 2020, negative perceptions of Black people, such as being labelled insufficiently ‘psychologically-minded’, continue to impede access to non-pharmacological treatments such as talking therapies[31].

Research and psychiatric practice: Recommendations for moving forward

Health inequalities and strategies to address them have been the focus of much research and policy, as exemplified by the seminal work of Sir Michael Marmot[32, 33] have been the focus of much research and policy. In contrast, the role of ‘racism’ in the onset of illness and the extent to which racism causes and/or perpetuates disparities in a healthcare system designed to eradicate them, remains relatively under-researched. In 2020, the #BlackLivesMatter protests in the midst of the COVID19 pandemic in which non-White people have disproportionately died, after diagnosis and hospitalisation, compared to White people with comparative health status[34], foregrounded the systemic racial injustice in relation to physical health. Given what is known about the relationship between physical and mental health, greater efforts to understand the relationship between racism, health and wellbeing is long overdue. In the UK[35] and US[36], racism is increasingly regarded as a ‘public health crisis’ that can no longer be ignored.

Asserting that “there’s no quality without equality”, the Royal College of Psychiatrists’ guidance on Advancing Mental Health Equality (AMHE) advocates radical, system-wide approaches underpinned by research to: i) identify inequalities, ii) design new ways of doing things, iii) evaluate those ideas, and iv) deliver improvements[37]. Findings from the Mental Health Act Review[26] and the Five Year Forward View for Mental Health and the NHS Long Term Plan[38] indicate that the views and experiences of patients and their families and a co-production ethos is integral to service redesign and commissioning that is fit for purpose in a multicultural society.

However, research that currently informs ‘evidence-based practice’ is predominantly quantitative with randomised control trials currently at the top of the ‘hierarchy of evidence’. Qualitative research, which seeks to bring insights from the perspectives of those experiencing healthcare, especially those whose health is most adversely affected, does not currently feature within this ‘hierarchy of evidence’. Including qualitative research within the hierarchy of evidence could serve to incentivise and foreground vital research that includes and amplifies the voices of patients, carers, racialised communities and healthcare practitioners. As indicated by Li and colleagues[39], those undertaking this kind of research are

less likely to receive funding and/or receive smaller awards or have their socially impactful work published in what are considered high-ranking journals. We therefore assert that changes to the funding system, which is vital to research career progression, is urgently needed. More equitable funding and greater transparency in recruitment and appointment processes will increase the likelihood of under-represented groups attaining senior leadership roles and/or membership to influential research funding panels or editorial boards with ability to influence what counts as 'evidence'.

We conclude that it is crucial for government, who invest in both research and healthcare services to recognise that, as with psychiatry and mental health, scientific racism, also underpins the foundations of academia. Research investments aimed at redressing systemic inequalities through co-produced research, holds the promise of broader academic and societal value.

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Brief biographies

Dawn Edge is Professor of Mental Health & Inclusivity within the Faculty of Biology, Medicine and Health at The University of Manchester. Her research focuses on addressing inequalities in mental healthcare experienced by racialised and marginalised communities. Dawn currently leads a multi-disciplinary team undertaking research to develop, implement and evaluate culturally-informed mental healthcare. She is also University Academic Lead for Equality Diversity & Inclusion with a particular focus on 'race' and students informed by intersectionality.

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Dr Erinma Ochu, MBE is interim director of Engaging Environments, a NERC climate solutions initiative. They are an AHRC Just AI/ Ada LoveLace fellow decolonising AI in service to racial justice. A neuroscientist and filmmaker, Erinma is Senior Lecturer in Digital Media and Communications in the iSchool at Manchester Metropolitan University. Undertaking co-inquiry with minoritised artists and communities, funded by Wellcome, they study new forms of information expression to extend human perception and collective consciousness to address climate justice.