DCP Annual Conference 2021
Doing What Matters: Value Driven Clinical Psychology in Action

Addressing Systemic Racism in Clinical Psychology: A Call to Action

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Patterns and Trends in Racism Embedded in Mental Health Systems

- **Consider**
  - Institutional processes that perpetuate racial inequalities

- **Devise**
  - Systemic solutions for systemic problems

- **Think about**
  - Occupational/organisational spaces

- **Work out**
  - Roles we can play & actions we can take
  - **to bring about lasting change**
Racial (and Cultural) Inequalities
UK statistics late 1970s onwards

Black / Ethnic Minorities (BME) more often:

• Diagnosed as schizophrenic / psychotic
• Compulsorily detained under M.H. Act
• Admitted as ‘Offender Patients’ (‘mad’ and ‘bad’)
• Held by police under S.136 of M.H.Act Transferred to locked wards
• Not referred for ‘talking therapies’ (and find these therapies do not ‘make sense’)


[Similar lists in various reports over the years]
Initially, these differences were attributed to ‘their cultures’ (blaming the victims), then to discrimination in society (‘bad apples’) but experience and studies from social-historical perspectives shows that the cause is:

**Institutional Racism in the Master’s House**

The culture of the system underpinned by psychiatry and clinical psychology (psy disciplines)

‘Inequalities’ are what is done to people – it’s about power

How racism permeated psy disciplines

(Adapted from: Fernando (2017) *Institutional racism in psychiatry and clinical psychology*)

**History of racism**

- Middle ages: vague racial awareness
- 1492: Columbus’ voyage to America
  - Expulsion from Spain of Jews and Muslims
  - Vasco da Gama reaches India
- 1625+: Atlantic slave trade (mainly British)
  - Sugar, cotton, tobacco
  - England
  - Slaves
  - Africa
- 1764+: Plunder of India
- 1807: Abolition of slave trade
- 1839-42: Defeat of China in Opium Wars
- 1865: 13th Amendment US Constitution
- 1884: Scramble for Africa
  - Plunder of Africa
- 1947: Liberation of India
- 1968: Liberation of Ghana
- 1971: Immigration Act UK

**Growth of the psy disciplines**

- Middle ages: Madness seen as ‘unreason’
- European renaissance:
  - Interest in Greek ideas on melancholia
  - Medical interest in ‘mind’
- 1586: *Treatise on Melancholy* (Bright)
- 1621: *Anatomy of Melancholy* (Burton)
- 1632: Medical Governor of Bethlem Asylum
- 1713: Hospital for Insane at Norwich
  - Public lunatic asylums
- 1774: Private Madhouses Act
- 1808: County Asylum Act
- 1841: Association of Medical Officers of Asylums
- 1851: ‘Drapetomania’ (illness of runaway slaves)
- 1901: British Psychological Society
  - Kraepelinian diagnoses; eugenics
- 1962: *British Journal of Social and Clinical Psychology*
- 1963: *British Journal of Psychiatry*
- 1971: Royal College of Psychiatrists
When inequality represents an underlying institutional process

When there is a pattern of inequalities in various fields affecting negatively a particular racial group this is likely to reflect (or be caused by) institutional racism.

(Institutional racism was described by Macpherson as the cause of the murder of Stephen Lawrence in 1993 (Home Department 1999) but described earlier by Stokely Carmichael (1967)] (Kwame Ture)


Statistics on racial inequality:
A pattern affecting a particular group of people

1. Diagnosis of schizophrenia / psychosis (Fearon et al. 2006) but not by black psychiatrist from Jamaica (Hicklimg et al. 1999)

2. Stop-and-search (Stop Watch, 2017)

3. Children remanded in London (Grierson, 2020)


5. Prison populations (Berman & Dar, 2013)

6. School exclusions (DOE, 2012)

7. Estimate of dangerousness by both black and white psychiatrists although less in the case of black professionals (Loring & Powell, 1988) (USA study)
References for slide ‘Racial inequality is evident in statistics’


The Transcultural Psychiatry Society - UK (TCPS)

Thrived in the 1980s and 1990s (into the early 2000s)

Some of its psychology & psychiatry members formed:

SIG (that became Faculty for Race and Culture) in the DCP

SIG at the Royal College of Psychiatrists that was prevented from ‘being political’ so only covers ‘culture’

Post-2000: Interest in combatting racism seemed to decline generally and

A ‘silence’ about race and racism descended *

(affecting discourse in both psychiatry and clinical psychology)

2020 / 21: “woke” meaning: “I was sleeping, but now I'm woke.”

Books by members of TCPS (UK)
A few questions for applied psychologists

Are BME professionals
- Adequately represented in position of influence?
- Properly consulted
  - In policy-making?
  - For reports on understanding diagnoses?
  - On ways of delivering psychology services?

Are BME service users
- Recognised as specialists by experience?
- Given a voice in training of trainees and qualified staff?

Are issues of importance to BME communities
- Adequately addressed at conferences?
- Agenda items at discussions of training programmes?
What degree of co-production drawing on service user /survivor expertise is evident in your services? What percentage of service users / survivors from a BME background are involved?
Why so little progress in overcoming structural racism?

Some barriers to change

❖ Conservatism of dominant groups (traditional way of working)
❖ Consensus of silence (‘better not talk about it’)
❖ Minority voices being silent through fear of repercussions
❖ Minority voices being silenced by institutional processes
❖ Diversity without inclusion leaving ‘snowy white peaks’
❖ Inadequate collection of data on disparities
Questions to ask ourselves

Are our senior psychologists modelling themselves as compassionate inclusive leaders?

Can we assume there is a consensus to change the status quo?

*Can we start a dialogue-now?*
The Conspiracy of Silence

- There are a number of strategies employed to take race talk off the table. In order to be an effective ally we must be mindful of when we are witness to the following:
  - **Doing nothing** – Actions or lack of actions model that race talk should be avoided
  - **Allowing the conversation to be side-tracked** (‘whataboutery’)
  - **Undue emphasis on appeasing those attempting to shut down the issue**
  - **Terminate the discussion** – table it ‘for another time’
  - **Becoming overly defensive**

Adapted from Derald Wing Sue (2015) Race Talk and the Conspiracy of Silence: Understanding and Facilitating Difficult Dialogues on Race
And so the Silence and Invalidation Continues……

“Race comes up you know, the faculty person is uncomfortable, they change the subject, they get support from some students in the classroom to change the subject and then we are all sitting there. It is a big elephant sitting in the middle of the room. The ignoring it is a feeling for many students of colour and some white students of complete invalidation “

Taken from Racial microaggressions and difficult dialogues on race in the classroom  (Sue and Torino et al 2009: 1105)

‘Increasingly, racism has ceased to be given space for discussion in sociology and the psy disciplines and their professional trainings, and all too often when race is brought up, or racism named, responses range from confusion, incredulity, discomfort, irritation and vacuous expressions’

Taken from Fifty ways to lose... your racism  (Nimisha Patel and Harshad Keval 2018)
Are Our Action Plans Fit for Purpose?

❖ Seven years ago The Snowy White Peaks of the NHS highlighted the scale of race discrimination in the NHS, the UK’s biggest employer of Black and Minority Ethnic (BME) staff.

❖ COVID-19 has shown much more needs to be done. Many health and social care staff have died from COVID-19, a disproportionate number of BME heritage. We know NHS staff infection was overwhelmingly due to occupational exposure whose causes include
  ❖ the disproportionate BME staff role in patient-facing services,
  ❖ their poorer access to appropriate PPE,
  ❖ the greater reluctance of BME staff to raise concerns,
  ❖ disproportionate deployment into “hotter” roles, and
  ❖ the greater presence of BME colleagues amongst agency staff.

BME staff have been largely absent from decision-making.
Are Our Action Plans Fit for Purpose?

❖ Firstly, equality, diversity and inclusion must become core business within Boards and within the leadership of each profession. No one should be a member of any NHS Board if they cannot confidently explain to staff and managers (and interview panels) why tackling race discrimination is important for the NHS and demonstrate what they are doing personally to achieve this. It must not be an optional extra.

❖ Secondly, every leader (and that could include within the Psychological Professions) must seek out and understand their local challenges, looking for risk not comfort.
Are Our Action Plans Fit for Purpose?

- Thirdly, a typical NHS “action plan” on race discrimination consists of improving policies and procedures, introducing better training, and some positive action. Yet research found ‘attempts to reduce managerial bias through diversity training and diversity evaluations were the least effective methods of increasing the proportion of women in management’. Similarly, Unconscious Bias Training, may improve cognitive understanding but has limited impact on decision-making. A primary focus on ‘policies, procedures and training’ will not change institutional discrimination any more than it would vanquish bullying.

- Fourthly, **Boards must be proactive and preventative**. If they don’t use research and data (including lived experience) to drive interventions, inserting accountability at every stage, they will fail.

- Rather than adding a BME member to a disciplinary panel, for example, managers must not start a disciplinary investigation unless they can demonstrate it is the appropriate and fair response to an alleged offence and not discriminatory in itself.
Are Our Action Plans Fit for Purpose?

❖ Fifthly Boards must embed accountability through clear measurable time-limited goals, ensuring managers and staff understand why, and then holding themselves (and their managers) to account as for other KPIs

❖ In recruitment, for example, ask managers to explain patterns of apparent discrimination in appointments and access to “stretch opportunities”. If there is no credible explanation, then insist outcomes must change and support managers to achieve them. Stop relying on individual staff to challenge individual appointment decisions

Research emphasises debiasing of processes not panels
Sixth, Boards and teams must **prioritise psychological safety** so they become inclusive, welcoming the difference that BME staff bring, recognising that when they are really included and valued, able to bring themselves to work, there are immense benefits for all.

Boards must understand that whilst improved BME representation is crucial, the benefits are limited without inclusive behaviours and culturally sensitive psychological support.
Are our Action Plans Fit For Purpose?

- Seventh, Boards and leaders must **model the inclusive behaviours they expect of others**, with consequences if they do not.

- Eighth, equality, diversity and inclusion are drivers of **service improvement** so must stop being primarily a matter of compliance delegated to junior staff.

- Ninth, the focus of NHS work around race equality must change. Remorselessly challenging racism must go hand in hand with supporting those who want to eliminate discrimination, question their own privilege and be allies.

- Finally, it is time to step up **national accountability**. Good governance has accountable metrics. Why, for example, are Trusts that cannot demonstrate serious progress on race equality still receiving a CQC Good or Outstanding rating?
Positive Developments Within the BPS and DCP to Become More Inclusive

❖ There have been some positive developments within the BPS and DCP to tackle some of the problems outlined in this presentation at a more systemic level

❖ Firstly, there is the work of the Presidential Taskforce for Diversity and Inclusion that in collaboration with the Diversity and Inclusion Manager is developing a five year strategy designed to embed EDI & Anti-Racism practices across all its structures

❖ There are also stronger more coherent links between the different Divisions: the webinars the Taskforce have produced attest to how much stronger and more vibrant we are together when drawing on a wider subject knowledge and research base to tackle issues from psychologically informed positions
Additional positive initiatives

❖ Within the DCP there has been substantial work done by the **Minorities Group**, particularly with relation to building support structures to encourage BME aspiring psychologists into the profession who still remain under-represented.

❖ There has been informative work produced by the DCP **Racial and Social Inequalities in the Times of COVID Working Group** and their recently published position paper *Racial and Social Inequalities: Taking the Conversation Forward*.

❖ A conference is being planned building on this work and their strapline and pledge around tackling racial inequalities.

❖ **The EDI & Anti-Racism Task and Finish Group** is strengthening its links and helping support EDI & Anti-Racism initiatives across the DCP Faculties.
The Case for Occupying Permanent Organisational Spaces

- Current momentum for positive changes within and across the organisation remains strong. However, this may not always be guaranteed once these temporary committees are disbanded. Since the disbanding of the DCP Race and Culture Faculty in 2014, a permanent home for Culture Race and Ethnicity remains conspicuous by its absence.

- As Suman has testified the work of the Transcultural Psychiatry Society and former Race and Culture Faculty needs to be remembered and included in the history of this organisation. It is important that they are not erased from the organisational memory.

- EDI and Anti-Racism needs to be at the heart of all that we do. As identified in this presentation, this is all of our work. We believe that there is a compelling case for a BPS Section for Culture Ethnicity and Race (modelled on Section 45 APA and with clear terms of reference) to be established to further inform and advance clinical practice and research in the field.