

## COMMENTARY

# The muddle of institutional racism in mental health

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The murder of George Floyd has reinvigorated the call for anti-racism across the Global North, and mental health bodies have joined this political moment. Yet, discussions of racism in mental health are nothing new (Bailey et al., 2017; Fernando, 2017; Fernando et al., 1998; McKenzie & Bhui, 2007; Nazroo et al., 2020; Richards, 1997). Certainly, the COVID-19 pandemic has revealed the extent to which racial inequalities play a detrimental role in health outcomes (Nazroo et al., 2020). The point of this commentary is not to summarise the works on racism and mental health. Rather, the following is a reflection on the hurdles of anti-racism in mental health, as situated within a neoliberal order. It will outline the challenges in addressing racism as a dynamic process in allegedly post-racial world—racism without racists (Bonilla-Silva, 2017).

The psy-disciplines in the UK have a history of confronting the racism endemic in their fields (Fernando, 2017). More recent reviews have found that BME communities are generally at higher risk of mental illness and more likely to be impacted by social detriments; less likely to access mental health services and more likely to do so through crisis care; more likely to be medicated (rather than be offered talking therapy) for mental ill health, while external risk factors such as poverty and racism are overlooked (Bignall et al., 2019). The structural inequalities underlying discrepancies in mental health, between white and BME populations, have also been highlighted in relation to the discrepant mortality rates due to COVID-19 (Nazroo et al., 2020).

Given these structural inequalities, scholars increasingly underline how anti-racist praxis in mental health must consider macro-level policies (Came & Griffith, 2018; Nazroo et al., 2020). The focus in this commentary will be the Prevent policy, the UK's counter-radicalisation duty and a wing of the nation's counter-terrorism strategy. This duty has made it incumbent on health staff to report individuals they suspect are susceptible to radicalisation based on elusive 'pre-criminal' risk factors.

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Prevent's pre-crime strategy is increasingly entangled within mental health settings. First, extremism risk factors are now embedded within the comprehensive risk assessments of several mental health trusts across the UK. In other words, all patients are screened for 'extremism' (Younis, 2021). Second, Prevent training employs extensive 'psychology talk', whereby elusive discussions of 'vulnerability' predominate the logic of averting future catastrophe (Knudsen, 2020; Younis, 2021). Third, novel mental health hubs have recently been developed to embed NHS mental health services with counter terrorism police. The majority of patients referred to these hubs are Muslim (National Police Chiefs' Council, 2017). These developments are indicative of the government's increased investment in pre-crime as a public mental health strategy.

Politics cannot be disassociated from public health. To this, the notion of policy-based evidence, as opposed to evidence-based policy, showcases the explicit role of political agendas underlying health-care strategies (Gregg, 2010). It has been argued that the Department of Health has employed policy-based evidence for years, leading to hospital bed shortage despite escalating waiting lists for patients (Jones, 2017). Similarly, the Public Accounts Committee (2020) expressed concern that the Home Office's decisions behind the hostile environment—a set of policies introduced to make life for irregular migrants in the UK unbearable—were made on 'anecdote, assumption and prejudice', rather than evidence. Naturally, this same observation has been levied towards Prevent (Mythen et al., 2017). The significance of policy-based evidence in racism cannot be understated, given how political discourse both pivots and reproduces dominant, racialised moral panics. In strategies like Prevent then, the racialisation of 'threat to national security' in public consciousness gives prejudice institutional legitimacy (Younis & Jadhav, 2020). Herein lies the significance of colourblindness.

## RACISM AND COLOURBLINDNESS

My research on Prevent in the National Health Service analysed policy documents, training and interviews to explore the deployment and impact of a counter-radicalisation duty. It found the government expended significant effort to deter any accusations of racism, despite the public's common-sensical association between Muslims and terrorism (Younis & Jadhav, 2020). Colourblindness is a key concept in this regard. As Bonilla-Silva (2017) explains, colourblind ideology no longer sees race as a significant political determinant in outcomes of inequality. To assume that *everyone* is *equally* susceptible to radicalisation is to assume a colourblind position towards an enterprise that is widely understood to be racist—the War on Terror (Kundnani, 2012).

Colourblindness encompasses a significant challenge we have at addressing 'new racism'—that is racism which avoids racial terminology, but still operates upon racial logics (Bonilla-Silva, 2017). Goldberg (2008a, p. 1716) ties the success of colourblindness to racial neoliberalism, which 'extends by building silently on the structural conditions of racism while evaporating the very categories of their recognisability'. Armenta (2017) makes a similar observation with the criminalisation and deportation of immigrants in the United States. The local police do not see themselves as active participants in a racist system; rather, by explaining 'their behaviour as "just" doing their jobs, the systemic racism embedded in these institutional policies appears to be the natural result of colourblind policies' (2017, p. 90).

Given the moral significance of national security, it is important to take stock of how racism in mental health revolves around the racialisation of risk (Fernando et al., 1998; Joseph, 2014). In relation then to the Mental Health Act—chiefly at the heart of discussions of racism in mental health—Fanning (2018, p. 3) observes its function is to no longer 'facilitate the improvement of health outcomes; rather, its chief purpose is to control and manage risk'. Furthermore, as recent analyses

have outlined, the centrality of race in pre-existing social orders is increasingly obscured through frames of threat, risk and security (Noble, 2018; Skinner, 2020). In other words, Europe's racist and Orientalist representation of Muslims as violent and regressive is not eliminated—it has simply been appropriated within the colourblind logic of risk.

There is a need then to distinguish between illiberal and liberal forms of racism (Mondon & Winter, 2020). Illiberal racism is the sort of racism that is thought to have been defeated with World War 2, heralded as absolutely incompatible with modern liberal democracies. It draws on the archetypes of Nazis or the KKK to refer to the wholesale demonisation of groups and communities. While the threat of illiberal racism in the modern world is very real, and indeed is significant even for health care, the real challenge today deals with liberal racism.

Liberal racism operates within the logic of colourblind but inevitably racist ideologies, such as nationalism, which sees some people within racialised groups as more worthy—and therefore more grievable—than others (Butler, 2016; Valluvan, 2019). A liberal racism will never demonise all members of a group equally, but favour some according to registers of cultural integration, national loyalty/security and economic value—model citizenry. As such, liberal nationalist politics may indeed still oppose open illiberal appearances of racism, such as those espoused by the Far Right.

The distinction between liberal and illiberal forms of racism reveals the limitation of reducing institutional racism as the organisational failure to account for personal prejudice (e.g. see definition of McKenzie & Bhui, 2007). In other words, to speak of racism is not only to relate to particular historical trajectories of Othering and how these are experienced, but to understand how contemporary institutions are implicated in the production of racist practices (in the case of Islamophobia, the military–industrial complex serves as an example, see Massoumi et al., 2017). This provides the theoretical bedrock of understanding why it is challenging to capture the impact of policies like Prevent, and why the label of institutional racism is so difficult to pin.

## INSTITUTIONAL RACISM REDUX

The subject of institutional racism in mental health has been reinvigorated. Fernando (2017) provides one of the more comprehensive histories of anti-racism in British mental health. Similarly, Nazroo et al. (2020), posit the need to appreciate how structural, interpersonal and institutional racisms mutually constitute one another, advocating for an anti-racist public health agenda. Here, it is worth summarising some of the ways institutional racism in mental health has been addressed.

Fatal incidents involving Black patients speak to the most glaring cases of institutional racism in British mental health settings. These tragedies are translated into inquiries—usually only produced following extraordinary efforts from the families of victims—in what Cummins (2015) describes as an ‘inquiry culture’. This inquiry culture serves a particular purpose, as Cummins (2015, p. 162) further elaborates, ‘the inquiry can be seen as to give assurance that risks are being managed or will be in the future’. Ultimately, he concludes such inquiries inevitably become scapegoating exercises. It appears then that the formal bureaucratisation of anti-racism is no guarantee racism is being taken seriously. The series of events which followed the tragic killing of David Bennet exemplifies this reality.

In a discussion on racism in health care, David Gillborn's (2008, p. 130) summary of the Stephen Lawrence and David Bennet reports is worth citing in full:

A few weeks later another inquiry began, this time into the death of David ‘Rocky’ Bennett, a black patient who died in psychiatric detention. The Bennett report, published in 2004, found that David had been treated as ‘a lesser being’ when he was killed by the

use of ‘unacceptable and unapproved methods of restraint’. The Bennett Inquiry, like the Lawrence Inquiry, had only come about as a result of a prolonged family campaign, in this case led by David’s sister, Dr Joanna Bennett. The Bennett Inquiry adopted the Lawrence definition of institutional racism and called for ‘Ministerial acknowledgement of the presence of institutional racism in the mental health services and a commitment to eliminate it’. In 2005, almost a year after the Bennett report was released to the public, the Health Department issued a response that did not acknowledge institutional racism but restated a bland commitment to ‘reshape front line services’. Later the same year the Home Office disbanded the advisory committee that had helped push for firmer implementation of the Lawrence Inquiry recommendations.

As Bradby (2010) explains, the ‘institutional racism’ frame drawn on David Bennet’s case reflects the same issues as Stephen Lawrence’s. That is, in so far as the Macpherson report of institutional racism served to deflect attention towards individual responsibility or policy change, so too did reference to institutional racism serve the same purpose in the NHS. The most significant element of Macpherson’s definition of institutional racism remains ‘unwitting prejudice, ignorance, thoughtlessness and racist stereotyping’. In 2007, the UK’s Department of Health unsurprisingly described ‘institutional racism’ as unhelpful, ‘the solutions lie in the hands of individuals not institutions’ (quoted in Gillborn, 2008, p. 131). This occurred months before the Commission for Racial Equality (CRE) was abolished and subsumed under an Equality Bill. In its final report, the CRE reiterated that the UK has failed to meet its duty for racial equality in every public sector (Craig & Walker, 2012).

If George Floyd reinvigorated the need to address racism in society, so too did David Bennet propel the need to recognise the centrality of race in mental health (Craig & Walker, 2012). To this, a 5-year action plan to tackle racial inequality in mental health settings, ‘Delivering race equality’ (DRE), was also proposed in 2005 (Lau, 2008). This included a yearly census, *Count Me In*, of the in-patients detained or treated under the Mental Health Act, with a special focus on ethnicity, which ran from 2005 to 2010. Promising a ‘whole system’ approach to issues of race in mental health, it sought to address discrepancies in mental health treatment. But census results found that the DRE action plan, in conclusion, had no material impact on the admission and detention rates of BME groups, especially Blacks (Care Quality Commission, 2011). The many causes of DRE’s shortcomings go beyond the scope of this article, but two stand out. First, race equality was never taken seriously enough by those in positions of power within mental health (Craig & Walker, 2012). Indeed, even the mention of racism could be cause for anxiety for white professionals (Bhui et al., 2012). Second, race equality does not figure centrally within national health-care policy, and the strict policy commitments within the NHS reflect this (Salway et al., 2016).

Meanwhile, it appears difficult to sustain the thought that institutions can be racist—in that their structures both facilitate and legitimise racist outcomes—when health-care staff are so clearly diverse. This speaks to the colourblindness of a neoliberal political climate, which sees issues of race as all but resolved. It is useful here to remember neoliberalism disfavors the conditions of illiberal racism—the total demonisation of the Other. Rather, contemporary post-racial liberalism sees ample opportunity for co-existence, especially if racialised minorities fulfil their role as model minorities (Valluvan, 2019). In the midst of increasing push for diversity as a panacea to racism, James Forman Jr.’s (2018) analysis of contemporary mass criminalisation in America offers a striking revelation with regards to the role of Black police officers, judges and wardens. This same point can be made about the government’s employment of ‘moderate’ Muslims, who then play various roles in the domestic War on Terror (Qurashi, 2018). As such, diversity does little to address the ideologies and their structures which produce these inequalities, translating racism as interpersonal problems to be measured and managed.

## THE NEOLIBERAL INDIVIDUAL: THE LIMITS OF DIVERSITY AND TRAINING

In a post-racial world, incidents of racism are inevitably understood in the frame of ‘bad apples’—individual aberrations within an otherwise faultless system. And, naturally, the solution to individualised problems is necessarily a question of training and personal accountability—unconscious bias training, cultural competence, etc. These fit squarely within the logic of neoliberalism. Neoliberalism has, legitimately, been criticised as a ‘catch-all’ for contemporary issues in health care (Bell & Green, 2016). While this may be true, it has been also possible to chart how a neoliberal climate has impacted mental health services, doubling down on individual responsibility (Cosgrove & Karter, 2018). Here, I will be referring to neoliberalism as a set of policies, relating to its impact on mental health on the one hand, and anti-racism within health care on the other.

The inevitable push to reduce racism to individual prejudice can be firmly grasped within an understanding of racial neoliberalism. As Goldberg (2008b, pp. 329–330) asserts, ‘race is a foundational pillar of modernising globalisation, both shaping and colouring the structures of modern being and belonging, development and dislocation, state dynamism and social stasis’. He further explains how the neoliberal state is primarily interested in issues of social control, while the fabric of social welfare is eroded through austerity and privatisation (Goldberg, 2008b, p. 335). Social control, as a political strategy in the face of growing inequalities, identifies criminals, immigrants and security threats as its primary concern and entrenches the web of their capture within public bodies—including the NHS. Inevitably, the figures of threat are racialised in public imaginary, as has been analysed in the campaign for the Brexit referendum or the scandalous detention and deportation of the Windrush generation (Virdee & McGeever, 2018; Williams, 2020).

Neoliberal identity politics celebrates diversity while maintaining the structures of exploitation. It reduces ‘race’ to a category we each own, to the exclusion of how dominant ideologies (i.e. nationalism) and social conflicts (i.e. War on Terror) *racialise* in the maintenance of global power structures. To this, David Goodhart’s appointment as commissioner at the Equality and Human Rights Commission (EHRC) is revealing of our political climate (Gentleman, 2020). Goodhart reveals a reductive neoliberal identity politics in the guise of multiculturalism, arguing the need for the cultural protection of ‘white self-interest’, thereby pivoting ‘white’ as one ethnicity among many (Goodhart, 2017). Meanwhile, the state continues to expand forms of racial governance, such as through the War on Terror, which racialises but renders it impossible to identify its strategy as ‘racism’ proper (Kapoor, 2013).

This is notwithstanding the fact that anti-racism initiatives in health care—when they do take place—are dissimilar, often superficial, and mostly educational in nature (Came & Griffith, 2018). Focusing on individuals, training is often reduced to discussions of diversity and unconscious bias training which ironically reify Whiteness as hegemonic and ‘race/ethnicity’ as exceptional characteristics to the norm (Vaught & Castagno, 2008). Colourblind systems cannot be challenged through training or diversity alone, for these do not fundamentally address why racism persists in the first place. Rather, issues of race become checkbox exercises, leaving the policies originating from liberal racist paradigms—that is, nationalism and capitalism—intact.

The function of critical race research then is not to simply study race-relevant topics such as prejudice, stereotypes and identity. Rather, it must expand the experience of being racially positioned within a wider discourse of paradigms, such as the Nation-State, which inherently figures race as significant in the imaginary of the majority population (Valluvan, 2019). Only then can we appreciate how racism operates outside of illiberal, hostile interactions.

## CONCLUSION

It appears both the rising interest in anti-racism on the one hand, and nationalist politics on the other, presents novel challenges. Just recently, Critical Race Theory was uttered for the first time in British parliament—only to threaten its employment in educational curriculums (Trilling, 2020). The UK government sees discussions of white supremacy—or anything which supposedly promotes ‘victimhood’—as inherently fracturing of the national consciousness.

In all this, history offers a sombre reminder: racism cannot be tackled head-on. No amount of training can reduce inequalities unless the causes of inequalities are understood and addressed. These cannot be addressed unless political structures are held to account, though those in power might view accountability as a threat:

When calls for change become so great as to threaten the stability of the system, then (temporarily at least) the interests of the white majority are seen to converge with those of the protesting minority group and certain concessions may be granted. However, once the apparent contradiction between rhetoric and reality has been addressed, then the real-world impact of the changes are reigned in or removed completely. Far from advancing equity, therefore, a critical perspective views public policy as largely serving to manage race inequality at sustainable levels while maintaining, and even enhancing, white dominance of the system. (Gillborn, 2014, p. 37)

Perhaps the issue with researching policies like Prevent is that such policies do not and could not exist in isolation. In fact, the research of individual policies like Prevent—reproducing the ‘inquiry culture’ in the academy—can potentially disassociate them from the wider, political impetus which inserted them into health care in the first place. This would suggest that issues of racism in mental health are inevitably aligned with those outside the field, such as the disproportional criminal convictions of people of colour or the recent introduction of police in Black-majority schools to prevent the development of gangs (Fekete, 2018; Nijjar, 2020). Herein lies the understated significance of Brexit’s impact on racism in mental health as well. As analyses of the Brexit referendum’s success have demonstrated, the push for stricter immigration (‘Fortress Britain’) drew upon racist representations of belonging, primarily directed at immigrants of colour (Virdee & McGeever, 2018).

In conclusion, it is worth noting that discussions of racism in mental health remain ongoing. The disproportionate sectioning of Black people has placed the Mental Health Act under considerable scrutiny, recently prompting a novel review (UK Government, 2018). Among the review’s various recommendations to ‘modernise’ the Mental Health Act, the UK government is now introducing a national organisational competency framework for NHS Mental Health Trusts, the ‘Patient and Carers Race Equality Framework’ (PCREF). The PCREF will serve as a toolkit for organisations to improve mental health access and treatment of BME communities, including the provision of culturally appropriate advocacy services (UK Government, 2021). More recent initiatives, such as the NHS Race and Health Observatory, look to tackle ethnic disparities in health as well (NHS Confederation, 2020). Time will tell if and how these initiatives prove successful. But given the political trajectory described so far in this commentary, it is worth noting: as nationalist and neoliberal forms of governance intensify, efforts to deal with institutional racism in mental health increasingly face an uphill battle.

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