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Multiple choice questions

1. Inception rates of schizophrenia in African–Caribbeans in the UK:
   a are higher in the older generation
   b are due solely to cannabis use
   c are higher in the second generation
   d are higher in siblings of the second generation
   e are always the same as those among Asians.

2. Rates of schizophrenia among African–Caribbeans are:
   a influenced by genetic factors alone
   b have nothing to do with social class
   c can be lowered by primary prevention
   d are due to high rates of unemployment alone
   e are owing to misdiagnosis alone.

3. Social factors shown to be associated with high rates of schizophrenia in African–Caribbeans are:
   a unemployment
   b poor housing
   c migration
   d social status
   e higher education.

4. Misdiagnosis by psychiatrists:
   a can explain away high rates
   b is owing to misunderstanding of some phenomena
   c never occurs in the UK
   d can be eliminated to some extent
   e is due to cultural stereotyping.

5. The assessment of patients with schizophrenia:
   a must take into account cultural factors
   b must include third-party information as far as possible
   c must be culturally appropriate
   d does not include physical assessment
   e does not include baseline investigations.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a T
b F	b F	b T	b T	b T
c T	c F	c F	c F	c T
d T	d T	d T	d T	d F
e F	e F	e F	e T	e F

Commentary

Swaran Singh

Bhugra & Bhui (2001, this issue) remind us of the social factors pertaining to the reported excess of schizophrenia in the Black Caribbean population in the UK. They suggest that population density, social isolation and fragmented social networks might play an aetiological role in schizophrenia. This intriguing suggestion has, as yet, no empirical validation and needs careful evaluation. Such research will

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hopefully generate further testable hypotheses and inform the debate about the causes of schizophrenia.

Causal explanations appeal to our medical training. Some might argue, however, that the social consequences of schizophrenia deserve equal if not greater attention than aetiological research, since poor social outcomes may be more amenable to effective intervention than putative social causes. This is especially relevant to Black patients since social inequities in health care provision overlap ethnic boundaries. Given the emerging evidence that Black patients have a poor relationship with mental health services, the social consequences of schizophrenia may be particularly harsh for this group. The problems of poor outcome and engagement with health services therefore deserve special attention.

Excess of schizophrenia in the Black population

The methodological limitations of early research, such as sampling bias, lack of standardised assessments, problems of ascertaining population size and concerns about misdiagnosis, have, to some extent, been addressed in studies that have confirmed higher rates of psychosis in Caribbean men using standardised research instruments and correcting for undernumeration (Harrison *et al*, 1997). However, a recent community survey conducted by the Policy Studies Institute (Nazroo, 1997) did not find elevated prevalence rates of non-affective psychosis in Caribbean men compared with White men. Caribbean men had higher rates of depression but were less likely to have been offered medication by their GPs. After adjusting for social status, those in a lower social class had higher rates of mental illness across all ethnic groups. The survey had a relatively high 'refusal to participate' and excluded patients in hospital and forensic services, where young Caribbean men are overrepresented. However, these alone are inadequate explanations for the difference between the findings of this survey and previous research. Therefore, a wider question remains: are there systematic differences in how ethnic minority patients are treated at each level between primary care and tertiary referral centres?

Ethnicity and outcome of psychosis

It is widely accepted that outcome of schizophrenia is better in developing countries than in the West (Sartorius *et al*, 1977). However, medium-term follow-up studies have not confirmed this in ethnic minority populations living in the UK (Harrison *et al*, 1998; Goater *et al*, 1999). The reasons for this discrepancy are unclear. We do not as yet know whether (and if it does, how) emigration influences family dynamics and support mechanisms in migrant communities. Commonly held views that some ethnic populations 'stay closer to their original culture' and are 'supportive' may be overgeneralisations that ignore socioe-conomic factors for which ethnicity is a proxy variable. Intergenerational and economic differences *within* ethnic groups may play a greater role in determining family communication, attitudes and coping mechanisms than differences *between* ethnic groups. We do not know about the protective influences, if any, of a stable family structure on the outcome of psychosis. Are extended families better able to contain distress, share burden of care and reduce the patient's sense of alienation, demoralisation and hopelessness? Bhugra & Bhui cogently remind us that such questions need careful empirical validation without recourse to assertions that simply reinforce cultural stereotypes.

Ethnicity, care pathways and engagement

The *Keys to Engagement* review (Sainsbury Centre for Mental Health, 1998) suggested that nationally, about 15 000 patients with serious mental disorders and multiple needs are not engaged with mental health services. A Danish study found that 26% of patients had dropped out of psychiatric treatment 1 year after first hospitalisation (Tehrani *et al*, 1996). Poor engagement therefore is not necessarily a function of chronicity. Despite the magnitude of the problem, there has been very little research on why patients disengage from psychiatric services. Several strands of evidence point towards a poor relationship between mental health services and Black patients, for whom effective engagement may be particularly important. GPs are less likely to identify psychological symptoms in ethnic minority patients (Odell *et al*, 1997). Black patients are more likely to deny having problems (Perkins & Moodley, 1993). Hence, at primary care level Black patients may be selectively disadvantaged in early recognition and appropriate referral. Black patients are more likely to come into contact with services through adverse pathways to care. Ethnicity itself is a strong determinant of coercive hospital treatment, independent of age, gender, marital status, social class, diagnosis and risk (Singh *et al*, 1998). Black patients

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are also less likely to be compliant with medication early in the course of their illness (Goater *et al*, 1999). While stereotypical views of young Black men may contribute to this excess of compulsory detentions, it is also likely that Black patients are less willing to accept voluntary admission. Coerced patients are not grateful for their experience of hospitalisation, even if they retrospectively agree that they had needed it (Gardner *et al*, 1999). Coercion is therefore particularly destructive of engagement.

Improving engagement

Poor engagement and mistrust of services creates a spiral of increasing disengagement as Black patients perceive mental health services as racist and authoritarian, do not comply with medication and decline voluntary admission, thereby increasing the risk of compulsory detention. Thus, each episode of care where compulsory detention is necessary causes further disenchantment among Black patients and becomes both a cause and a consequence of worsening engagement. Simplistic explanations of racism underlying all such issues serve only further to drive a wedge between services and their users.

The onus for improving engagement and ensuring adequate care is upon the services and not upon the Black community or patients. Politically correct recourse to 'colour-blind' policy-making and service provision may do a great disservice to a very vulnerable and needy group of patients. The challenge for future research is to design studies that neither underplay the importance of psychosocial factors by focusing too narrowly on ethnicity nor ignore differences in how various ethnic groups relate to, and are treated by, psychiatric services.

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