

Racism and inequity in mental healthcare: A call for recalibration of healthcare policies in Europe

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Abstract

Inequitable mental healthcare is becoming an issue that needs urgent attention. Minority groups, especially Afro-Europeans or people of African origin, are likely to feel the impact in light of the increased level of mental disorders recorded amongst the group. In Europe, the institutional response to this problem is inadequate, and it demands a call for change in policies and direction. The inequities observed in mental healthcare might be explicated in terms of discrimination, unfair policies, and racism. It is known that social groups are likely to be affected by structural racism and unfair policies. Recent studies show that those who experience minority stress, discrimination, cultural stress and racism have a greater risk level to develop illnesses. In the literature, there is paucity of studies on the structural links between racism and unfair policies and their relationship to mental healthcare inequities. This viewpoint focuses on how unfair policies and structural racism may contribute to mental healthcare inequities in Europe, in order to give some recommendations to policymakers, scholars and other stakeholders. A pragmatic shift towards equitable care requires policymakers to address unfair policies and structural racism, which are elemental causes of health inequities and mental disorders.

KEY WORDS: Europe; ethnicity; health inequity; healthcare policy; migrant health; minorities; racism; mental health; public health; unfair policies.

INTRODUCTION

In the Western world, in-depth knowledge about the mental well-being of people of African origin is scant. In Europe, barriers exist for minorities due to unfair policies and bias, making access to mental healthcare for minorities much more complicated than the majority population [1-3]. Generally speaking, results show that ethnic minorities are more vulnerable to enormous unbalanced pressure than the majority population, because of marginalisation and pressure to assimilate or acculturate. Research about acculturation and health is widely present in the knowledge base; however, research might not address the effect of discriminatory experiences faced by minorities [4]. Little is done in Europe to tackle the factors that lead to illnesses amongst Afro-Europeans or people of African origin due to their engagement with systems that interact with social forces, ideologies and processes. Additionally, research indicates that people exposed to discrimination, marginalisation and racism are likely to develop illnesses [5]. Discrimination has been defined as a set of 'policies, practices, and

behaviours that perpetuate inequities between socially-defined groups' [6] and it is most apparent at the level of individual social interactions, at the institutional level, for example by affecting access to employment and healthcare, and at the structural level, whereby societal norms can systematically disadvantage certain group like African Americans [7, 8]. Structural racism has been defined as "the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups" [9, 10]. For treatment to be effective in mental healthcare, it is essential to address these social determinants of mental disorders. This paper aims to demonstrate how unfair policies and structural racism give rise to mental healthcare inequities in Europe, in order to offer ways to achieve equitable care for all.

DISCUSSION

Unfair policies and mental healthcare inequities

There is a preponderance of research that

TAKE-HOME MESSAGE

Meaningful policies should reduce the impact of inequities on the mental health of Afro-Europeans, by including African values in healthcare policies. Furthermore, European stakeholders should confront structural racism and unfair policies, which are elemental causes of health inequities head-on to achieve equitable care for all.

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shows psychosocial factors and culture to be relevant to the concept of mental disorders [11]. In the Western countries, minorities' psychosocial experiences are, in most cases, different from the majority population due to exclusion and institutional challenges. The constant exposure to discrimination and racism has an impact on their mental well-being. From another angle, studies have established the association between cultural stress and mental disorders. Minorities experience cultural stress at a higher level than their white counterpart, which is linked to an increased level of mental disorders amongst minorities [12]. Further, research consistently shows that patients' lived experiences are crucial to treatment when dealing with mental disorders [13]. People of African origin in Europe have lived experiences that are different from the majority population. It is discernible that the current policies to reduce mental disorders in Europe will not benefit people of African origin because their values are not incorporated into policy-making. The treatment of mental disorders in Europe without addressing its psycho-social nexus is likely to benefit only the majority population, if the social determinants of certain mental disorders are linked to racism and discrimination. Again, this is evident in the high morbidity rates amongst these minority groups. In the United Kingdom, minorities are more likely to be diagnosed with a severe mental illness than the white majority. It is mainly the case for those with spiritual connection to Africa [14]. For example, people of African origin are more likely to struggle with mental illness in Europe due to societal and systemic challenges associated with unfair policies and racism. Findings supported by research data in the United Kingdom, Germany, Italy, the Netherlands, France and Spain, showed that post-migration factors may affect their mental health. In the UK, mental health practitioners are likely to consider people of African origin as dangerous, leading to exclusion and physical restraint. For incident diagnosed schizophrenia, people of African origin are at higher risk than the white majority popula-

tion (relative risk = 6.0; 95% CI 3.5 to 10) [15-17]. The policies to address minorities' mental disorders in Europe have failed to address the plights of people of African origin, because policymakers preclude their values when making mental healthcare decisions. The challenges faced by people of African origin shape their lived experiences, and have been linked to a higher level of mental disorders prevalent in the group. Even though these higher rates amongst people of African origin in Europe are well-registered in research and are linked to social and economic disadvantages, no substantive measure has been taken to address these issues [17]. For example, a study found the plights of people of African origin in Europe, such as social and economic disadvantages, to be the root cause of their higher levels of mental disorders [18]. Moreover, the continued exclusion of people of African origin's values from research design, health policies and the systematic failure to address these issues through policies are factors expanding health inequities. Recommendations from studies that have called for culturally-sensitive care in healthcare have not been implemented, adding to the ongoing health inequities in our society [19, 20]. Mental healthcare in Europe and research are in dire need of a meaningful representation of people of African origin's data as intercultural understanding aids recovery. Most healthcare policies in Europe are based on existing research; if the factors recognised in developing mental psychoses in people of African origin are not addressed, it is understandable that the group will not gain from policies designed to benefit the majority population. Furthermore, most mental health studies in Europe exclude the local-psycho-social experiences of people of African origin, prompting studies to call for greater investment in this area to reduce the risk of severe mental illness and close the inequalities gap in health [18]. Taking into account the scarcity of mental healthcare studies on people of African origin in Europe, it is obvious that this group will not benefit from policies that prevent their local- psychosocial experiences from research

design. Apart from the scant mental health research existing for this group, evidence suggests that subjects of forced migration, refugees, for example, suffer from mild or severe mental conditions [21]. It is recommended to provide value-based treatment to address the factors that constitute their mental conditions. In certain European countries, there is no equality and non-discrimination law to protect people of African origin, exposing them to harassment through ethnic profiling by authorities [22]. All attempts calling out discriminatory policies in this area and healthcare which are interconnected have got no response from the authorities [23]. If an individual is of African origin in Europe, he/she is likely to experience discrimination [24-26]. The follow-up question would be: When will Europe put people of African origin's mental health struggles on its agenda? It seems to have gone under the radar. One might expect the exchange of diverse narratives in research designs for mental healthcare studies, but unfortunately, the opposite is the case. Health inequities cannot be addressed without rooting out unfair policies. The constant exposure to discrimination can increase psychosocial stress, which can lead to severe mental disorders. Occurrences associated with discrimination and racism lead to inequities across socioeconomic environments. For example, in Ireland, this issue has not been addressed by government's healthcare policies. As one African-Irish puts it: *"As black Irish teenager in a country that's predominantly white, I also felt the pressure and the burden of not being accepted due to the constant encounters with discrimination and stereotyping. I did everything within my power to distract my peers from my skin colour. I gave my all in sports and pushed myself to be the best I could be, in both athletics and rugby, so I could be accepted at some point, you start to lose your own identity working so hard to create one for other people"* [25].

People of African origin's mental health implications in Europe due to constant encounters with discrimination and racism are critical issues that need to be addressed. A study shows that the risk level for psychosis was doubled

for those that experienced racism [27], but racism can affect emotional and behavioural difficulties in children and adolescents [28, 29], as well as anxiety, depression and suicide risk in adolescents and young adults [30, 31]. Calls to address the underlying factors and examine the core causes of these disorders linked with discrimination in Europe have been brushed aside. Unfairness in research design and policy is a significant factor that threatens the attainment of equitable care.

Racism and health inequities

Unfair policies are one of the fundamental causes of health inequities and diseases. Europe should change the existing policies in order for healthcare to be more equitable for all. This can only be achieved by introducing meaningful policies to address the social determinants that expand health inequities. Systems that turn blind-eye and pretend that these issues do not exist directly play a part in advancing the factors that cause health inequities. Thinkers have long conceptualised racism as a multi-level dynamics varying from interpersonal level to structural. The tip of the issue is the cases that can be seen, such as racist attacks on people of African origin in Europe. The one that is oblivious to the public representing the base is the less detectable structure, termed structural racism [32]. Structural racism has been described as the product of interaction within systems that includes macro levels, meso levels, social forces, ideologies and processes. The result of this interaction reinforces inequities among racial and ethnic groups [9, 33]. This form of racism is not easily eradicated, because it does not entail intent or actions on an interpersonal level. It is repositioned and redesigned continuously to ensure its perpetuation. If social conditions are fundamental causes of certain diseases, it would be appropriate to address such issues [34]. In Europe, people of African origin face situations and processes linked with racism and discrimination. One Swiss citizen of African origin chronicled her experience: *"A teenage black girl who gave her name as Pauline said: "Yes, I suffer from racism*

every day and I think there is a problem in Switzerland regarding this. Switzerland must also change. We have racism more implicit than some countries, but it also exists and it is also strong” [35]. In Germany, the number of incidences is equally alarming, as reported: “Germany has an ongoing problem with racial discrimination and does not give enough consistent legal support to victims”, said Bernhard Franke, the acting head of the anti-discrimination agency, when presenting the report. The feeling of being left alone with injustice has “dire consequences in the long run that endanger social cohesion”, Franke warned, adding, “Discrimination wears people down” [26].

The shocking aspect of all these reports is the institutional neglect to initiate appropriate policies to protect people of African origin against attacks, harassment and discrimination and failure to address how these factors lead to health inequities.

The situation is even dire in Italy, where people tend to pretend that racism does not exist. Luciano Scagliotti, an independent consultant on human rights and equality and coordinator of the National Platform of the European Network Against Racism (ENAR), explained that “the Italian government has taken no action to address the long-standing systemic racial inequalities in the country...not even a discussion in the parliament has taken place. In part, this is because in Italy, people pretend that racism doesn't exist” [36].

Calls to address these issues have been unanswered, leaving people of African origin in Europe to deal with the repercussions on their health attributable to discriminatory experiences, unfair policies and racism. Similar experience is also noted in Spain, where people of African origin frequently face discrimination because of their historical connection to Africa, as one Afro-Spaniard detailed her own experience: “I was traumatised” she said. “It made me feel like I didn't fit in. Now I want to love myself as I am: my race, my culture, my eyes and my skin. And I want to know other races that I don't yet know and that I love”, she added, explaining that every time she goes into a store, the staff check her pur-

se: “When they see I haven't stolen anything they apologise to me”, she said [37]. This discriminatory experience is prevalent across Europe for people of African origin. However, most European countries do not monitor or record racist incidences, making data-driven and integrated solutions non-existent. It might be an area of interest for future studies. Findings from other studies highlight the links between structural and interpersonal racism. For example, institutional apparatuses have been described as the point where one observes the concentration and mediation of structural racism and interpersonal racism [38]. The interpenetration of these different forms of racism is detailed in a similar study addressing structural racism [39]. Incidents of racism are seen as an attack on a group of people or community; one does not need to experience it individually to feel its impact on health [40]. Evidence suggests that this is responsible for the higher level of mental disorders registered in minority groups [41, 42]. As these issues continued to be unaddressed, the summation of these issues has led to inequalities across minorities' lives, such as well-being and social stratification sphere. Most research supports the claim that people of African origin are likely to have a greater risk of mental disorders due to higher level of psychosocial stress stemming from their experiences with discrimination, racism and unfair policies. One might expect the existing policies to address these issues and eliminate the plights of people of African origin. The new generation of Afro-Europeans or people of African origin might do well in specific sectors, but this does not necessarily mean improvements elsewhere due to the depth and continuous persistence of structural inequalities encompassing the most critical areas of their life [43]. One can add that the policies in place are ineffective and have failed to protect people of African origin amid racist attacks, economic inequality and constant exposure to discrimination; new directions are urgently needed. Of utmost importance is the immigration policy that prevents access to healthcare for minorities due to excessively bureaucratic measures

that blocked them from getting care. More human policies should be put in place within the boundary of immigration laws that must prevent the exclusion of the sick regardless of their immigration status [44, 45].

The reluctance in Europe to have an open conversation and dialogue about the psychosocial stress affecting the mental health of people of African origin in their community is part of the problem. As we know that shying away from uncomfortable discussions does nothing to change a dire situation that can be corrected with appropriate policies. People of African origin's health values should be considered in mental health research designs. Instead, there is a lack of interest from policymakers in Europe to address this issue, thus the insufficient data in the mental health database. For instance, in the United Kingdom, people of African origin with mental disorders are less likely than the white majority to receive psychologically-based interventions [46]. Moreover, people of African origin predominate assertive outreach services at higher rates that can administer supervised treatment orders, undermining value-based practice [47]. In such treatment centres, personal agency and autonomy are usually suspended when imposing the treatment on patients. Also, Afro-Europeans or people of African origin with mental disorders have higher readmissions rate even with reduced negative symptoms [48]. Research also shows that people of African origin are at increased risk of detention under the 'Mental Health Act' [49]. Additional data is needed across Europe to enhance existing research, considering most countries do not monitor racist incidences. Studying how racism affects the group would be the first lap to determine some of their health values. Implementing culturally-sensitive care by culturally-competent providers is part of the puzzle to achieve equitable care.

Path towards equitable care

First, it should be understood that elemental causes of health inequities need appropriate policies to be eliminated or reduced. Even if interpersonal racism was to be eliminated,

structural racism would be hard to eliminate since individual participation is not required for its perpetuation to continue. It has been suggested that policymakers recognise the drastic effect their policies can have on Afro-Europeans, if the values of people of African origin are continued to be excluded from decision-making. They should support decisions that account for social-determinants of health within the population by focusing on minorities' health compared to general population health data. International studies can be used as a guide. However, local factors must be thoroughly examined and studied during the decision-making process, taking into account that the concept of mental disorders entails local, cultural and environmental factors. It will be imperative to state that mental disorders are beyond monolithic elucidation with determinants of the category encompassing multi-levelled features. It is important to emphasise our lived body as a pre-reflective mode of being in our shared world, and alteration to this shared world is allegorical for certain mental disorders [50]. Second, as the evidence presented in this paper shows that people of African origin in Europe are likely to develop mental disorders, it is essential to investigate the local-psycho-social factors behind the higher morbidity rate compared to the majority population. Rather than providing a singular mental health policy for all, specific policies should be provided that address people of African origin's experiences with the system and how this interaction affects their well-being should be monitored. It is crucial when addressing structural racism and unfair policies to add context and historical ramifications on current events where pluralistic values are in play. Third, it is vital to advance the state of the art by implementing transformative policies, which can be achieved by allowing diversity of perspectives through solidarity. For example, people of African origin's representation in Europe's policy-making is essential in removing structural racism and unfair policies. It would remove the current roadblock where existing policies to eradicate health inequities

have failed to eliminate the issues and protect Afro-Europeans or people of African origin due to lack of participation and limited understanding about the socio-health-cultural values of people of African origin. Europe must move swiftly towards inclusive policies. The impact expected from existing policies is never felt where it matters most, pushing people of African origin in Europe to the point of disadvantage. Another aspect germane to this theme is the influence of culture and its relation to mental health since the meaning of cultural value can be historically specific. It should be studied to determine whether cultural barriers add to health inequities. Additional research might be needed in pluralistic settings to examine the relationship between culture and mental health to recognise social determinants of disease and support policies that will address the factors that lead to health inequities. Fourth, mental health is an area where diverse values are in play and a field in dire need of meaningful diversity. European stakeholders should tackle structural racism in a more meaningful manner. The current empirical evidence on how racism adds to the risk of severe mental illnesses amongst people of African origin and its link to health inequities requires further conceptual clarification. Eliminating this hurdle will require an integrated approach, which might be the way out of this predicament. The integrated approach offers a comprehensive understanding of how to tackle structural racism and unfair policies in health. Consequently, it will provide cues on how population health data might be used to address the thorny issue of health inequities. As part of the integrated approach is to apply understanding across disciplines to help conceptualise the difficulties facing current research data. More importantly, studies and research should be widened to answer how racism, discrimination, and unfair policies increase the risk of severe mental disorders amongst people of African origin and how this can be lifted to achieve equitable care for all. Fifth, the multi-levelness manifestations of racism will require examining multiple forms of racism, so studies on

structural racism should refrain from seeking a one-dimensional solution to this complex issue. As it can be local-specific, it would be important not to assume that the effects of structural racism would be similar across the board; its manifestation may be different and time-specific. As a result, its conduit that conveys its manifestations should be restructured to produce equitable healthcare for all. It would be false to think that reducing the impact of interpersonal racism would eradicate racism. For example, eradicating one form of racism might give a false impression that it is a non-issue. It is essential to recognise that the manifestations of racism are neither static nor rigid. On the right course, studies should analyse other forms of racism and how they interact and link with structural racism. In Europe, achieving this goal is difficult seeing the lack of comprehensive data about the values of people of African origin. It would be advisable that institutions develop tools to be used to monitor racial bias. As described in this viewpoint, policy not mechanism is vital in removing and reducing structural racism's impact on minorities' health. Operations of institutions should be transformed through policies to deal with health inequities. Furthermore, it would be essential to direct our attention to various institutions' interlinks and boundaries and study how institutional policies shape minorities' experience. A closer look should be devoted to institutions' negative structures that reinforce health inequities to know where to implement change. This apparatus should be reshaped to support fair policies, thus providing equitable care for all. It is critical because research data about the seriousness of the higher risk of mental disorders due to discrimination and racism may be scarce. However, it is well-detailed in general medicine literature. Again, this viewpoint is mainly concordant with other studies that have called for redirection of policies, advising on the need to include the values of minorities in research design and policy-making [3, 27, 51]. As previous research in mental health literature has supported the ideas put forward in this paper, it is widely accepted that under-

standing the differences in cultures can positively affect the outcome of therapy. Mental health practitioners are not equipped with the tools, and they are having trouble grasping these differences. This can have severe repercussions for people of African origin in Europe receiving psychiatric treatment.

Unfairness in policy and structural racism are fundamental causes of mental healthcare inequities in Europe. Only through appropriate policies can this gap be closed. This paper confirms the interpenetration of various forms of racism and how they affect Afro-Europeans' health outcomes, and how this can be traced to mental healthcare. The leadership at institutions should understand that their roles are vital in breaking the fundamental causes of health inequities. Along with it, an integrated approach is put forward to prevent one-dimensional and insular approaches when approaching the complexities of structural racism and unfair policies. Conceptual and expansive research might be needed to improve existing research on how interpersonal racism impacts the health of people of African origin. Considering the current policy's ineffectiveness to address the higher level of severe mental conditions amongst Afro-Europeans or people of African origin in Europe. It is recommended to study mental healthcare-seeking attitudes amongst people of African origin and address the group's variability to bridge the current gap in the

literature. A global action is needed to prevent a societal apocalypse due to continuing disparities amongst the populace [52-54]. In a pluralistic society, culture valorises individuals. It would be appropriate to study how culture affects the mental healthcare-seeking attitudes amongst people of African origin; this could open mental healthcare barriers and help close the existing health inequities gap in mental healthcare.

CONCLUSION

This paper reveals how the interaction of various forms of racism expands its perpetuation and its severe impact on the mental health of people of African origin. Scholars and policymakers should support mental health studies covering this issue as key social determinant of disease. In conclusion, the care of minorities is beyond rules as history continues to reinforce this assertion. European stakeholders should develop inclusive policies, recalibrate existing policies to reduce the impact of discriminatory experiences on the mental health of people of African origin, hence reducing health inequities.

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