It's kind of like psychiatrists have become the priests of scientism.

That's really a misunderstanding and it's amazingly widespread.

There's this attribution to us of some special form of human wisdom. It's amazing how intelligent people tend to have these feelings. It's just so strange the things that we get projected upon us as psychiatrists.

Were your parents religious?

Not at all. They were very Jewish, but not at all religious. I mean, if you've seen Woody Allen movies, yes? That's my father. But they grew up at a time when being religious they thought was superstition.

And if we were going to be psychoanalysts about this, do you think that you might have had some unconscious urge to rebel?

Well, I don't actually think that my interest in religion was primarily rebellion. It was something much more deep. You know I read a lot of Walt Whitman and William James's *Varieties of Religious Experience* when I was a teenager. I was reading Alan Watts, reading a lot of Gary Snyder poetry and other 'Pacific Poets'. I was trying to make sense out of life in the way that I emotionally came toward it.

Is it mainly poetry that you read in terms of the arts?

I certainly would read poetry more than I would read fiction nowadays. I certainly started out with it. I mean, Gary Snyder is probably my paradigmatic poet of interest, and Kenneth Rexroth.

I always have several books of poetry on my table that I read.

What do you get out of those?

The best kind of poems are just like little prayers, little senses of pulling on the special, the contingent, even – if you want to use the word – 'sacred' out of our everyday life experience, which as we know kind of rushes by us. Poetry is kind of grabbing this potent observation and thinking through the emotional implications of often very small things in our lives.

References

1 Kendler KS, Zachar P (eds). *Toward a Philosophical Approach to Psychiatry: The Writings of Kenneth Kendler*. Cambridge Scholars Publishing, 2019.

2 Kendler KS. The dappled nature of causes of psychiatric illness: replacing the organic–functional/hardware–software dichotomy with empirically based pluralism. *Mol Psychiatry* 2012; **17**: 377–88.

3 Kendler KS, Parnas J, Zachar P (eds). *Levels of Analysis in Psychopathology: Cross-Disciplinary Perspectives*. Cambridge University Press, 2020.

4 Kendler KS. Toward a philosophical structure for psychiatry. *Am J Psychiatry* 2005; **162**: 433–40.

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COLUMNS

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Systemic racism and mental health services: the time is now

The killing of George Floyd refocused global attention on racial injustice. UK Covid-19 death rates are highest among Black, Asian and minority ethnic (BAME) groups,[1] with systemic racial inequality a central cause.[2] Although BAME people face many inequalities, Black people's unique experiences require particular attention.[3]

In mental healthcare, we must consider links between psychiatric symptoms and experiencing racism, systemic racism within services and medico-legal interfaces. The *Delivering Race Equality in Mental Health Care* (DRE) agenda[4] was prompted by the 1998 death of David Bennett, an African-Caribbean patient, following in-patient restraint. DRE prioritised reducing fear of services, developing culturally appropriate therapies, and engaging BAME groups and patients in training, policy development, service planning and provision.

A DRE progress review[5] advocated dedicated community development workers, engagement projects, training, clinical trailblazers and measuring progress. Patients, professionals, campaigners and academics attributed continued race inequality in mental healthcare post-DRE to institutional racism, inadequate training, poor system design and lack of an empowering culture.[6]

In our experience, DRE is not prioritised. Core training competencies of 'cultural diversity', evaluating institutional prejudices, respect for diversity and evaluating biases are neglected. Despite a strong position statement,[7] racism is absent from MRCPsych examinations. Static e-learning modules replace interactive, in-person training that could stimulate engagement, discussion and reflection. Black leadership and collaboration with Black community stakeholders are lacking in mental health trusts serving largely Black populations.

Mental health service leaders must role-model, reflecting on personal and workplace unconscious biases.[8] We should

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each ask of our own organisation, how equitable is provision? Do Black patients have equal access to psychological therapies and specialist services? Are their perspectives represented? Do we foster dialogue with local communities? Do Black staff experience disproportionate bullying and harassment? Can they speak up if safeguards are lacking? Identifying and ameliorating clinical inequalities should drive research, so that treatments meet Black patients' needs.[9]

'We do not need another review, or report, or commission to tell us what to do' about race inequality in the UK,[10] nor in mental healthcare. To address mistrust, services must acknowledge and address inequalities experienced by Black patients. We welcome RCPsych's appointment of presidential race equality leads and hope they will forge multidisciplinary alliances to mainstream anti-racism across mental health professionals.

It should not have taken a death to trigger the biggest race equality focus in mental health services' history, nor should it have been so rapidly forgotten. Black stakeholders must be empowered to occupy positions of influence, but it is not Black staff or patients' responsibility to effect change; organisations must be accountable. In a mostly White-led profession, tackling systemic racism will inevitably cause discomfort. Mental healthcare, with its recognition of transference and countertransference, and prioritisation of supervision, reflection and psychotherapeutic skills, is well-placed to lead the difficult discussions the health service needs. Silence is not neutral. The time is now.

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Declaration of interest

None.

1 Public Health England. *Disparities in the Risk and Outcomes of COVID-19*. 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf.

2 The Health Foundation. *Emerging Findings on the Impact of COVID-19 on Black and Minority Ethnic People*. 2020. Available from: https://www.health.org.uk/news-and-comment/charts-and-infographics/emerging-findings-on-the-impact-of-covid-19-on-black-and-min [cited 21 Jun 2020].

3 Matiluko S. When it comes to Black Lives Matter, we need to focus on the B in Bame. *Independent* 2020. Available from: https://www.independent.co.uk/voices/black-lives-matter-uk-protests-bame-priti-patel-boris-johnson-a9563671.html [cited 6 Jul 2020].

4 Department of Health. *Delivering Race Equality in Mental Health Care. An Action Plan for Reform Inside and Outside services and the Government's Response to the Independent Inquiry into the Death of David Bennett*. 2005. Available from: https://webarchive.nationalarchives.gov.uk/20130123204153/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773 [cited 20 Jun 2020].

5 Department of Health. *Delivering Race Equality in Mental Health Care: A Review*. 2009. Available from: https://lemosandcrane.co.uk/resources/DoH%20-%20Delivering%20Race%20Equality%20in%20Mental%20Health%20Care%20-%20A%20Review.pdf.

6 RAWOrg. The End of Delivering Race Equality? Perspectives of Frontline Workers and Service-Users from Racialised Groups. 2011. Available from: https://www.mind.org.uk/media-a/4397/the-end-of-delivering-race-equality.pdf.

7 RCPsych. PS01/18 Racism and Mental Health Position Statement. 2018. Available from: https://i.emlfiles4.com/cmpdoc/3/5/5/6/7/1/files/49288_ps01_18.pdf?utm_campaign=1920755_Update%3A%20BLM%20and%20COVID&utm_medium=email&dm_i=3S89,1562B,2B6FXZ,41J6I,1 [cited 21 Jun 2020].

8 Saad LF. *Me and White Supremacy*. Quercus, 2020.

9 Smith S, Gilbert S, Ariyo K, Arundell L-L, Bhui K, Das-Munshi J, et al. Multidisciplinary research priorities for the COVID-19 pandemic. *The Lancet Psychiatry* **7**:e40. doi:10.1016/s2215-0366(20)30250.

10 Lammy, D. Britain needs leadership on race inequality. Not just another review. *Guardian* 2020. Available from: https://www.theguardian.com/commentisfree/2020/jun/16/race-inequality-review-boris-johnson-black-lives-matter-david-lammy [cited 21 Jun 2020].

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Clinical course of 12 patients on a Covid-19 dementia isolation ward

Older adults have been particularly vulnerable to outbreaks of severe acute respiratory syndrome coronavirus 2 (Covid-19), and mortality rates increase with age.[1,2] Physiological comorbidities and nutritional status are contributory factors, but there is limited understanding of the influence of mental illness, particularly for patients with dementia.[3–5] Furthermore, cognitive impairment may also increase the risks of contracting Covid-19.[6]

We have summarised our experiences from a psychiatric in-patient unit to describe the clinical outcomes of 12 patients admitted to a dementia specialist ward, which later became closed to admissions after nine of the patients were isolated with confirmed or suspected Covid-19. The following patients, all over the age of 74, were selected to illustrate the typical clinical course that was observed in the most unwell patients. To ensure anonymity, patient initials, ages, and gender identifiers have been removed.

In Case 1, the patient had diagnoses of mixed Alzheimer's and vascular dementia, type 2 diabetes mellitus, hypertension and previous traumatic subdural haemorrhage. Isolation was commenced after a new cough, low oxygen saturations and vomiting were observed. The patient was then transferred to the acute hospital and treated with empirical antibiotics. Despite this, the patient refused all oral food and fluids, and a decrease of 24% of pre-Covid total body mass was recorded. The patient later developed hypernatraemia and an ischaemic left leg and

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