Chapter 1

Systemic Racism: Big, Black, Mad and Dangerous in the Criminal Justice System

Sharon Walker

Introduction

I have written elsewhere about the issue of black academics in the UK experiencing mental ill health (Walker, in press). Yet, it is only one emerging area in an existing phenomenon of black people disproportionately diagnosed with a mental illness in other institutions such as the criminal justice system (CJS). The Black Manifesto (2010) states:

> we can objectively measure structural inequalities, discrimination and disparities in the criminal justice system, employment, education, poverty, health and housing. Disparate outcomes for Black and Minority Ethnic people in the UK have NOT been eliminated and, in fact in some areas, have increased. (p. 2)

The Black Manifesto note Britain's pride in its historic contributions to setting global standards for democracy and the rule of law yet it has not managed as a country to reduce racism or the over representation of black people with mental ill health. Findings from the Angiolini Report of the Independent Review of Deaths and Serious Incidents in Police Custody (2017) highlighted evidence of racial disproportionality in police restraint deaths. Indeed, during a 12-day period in 2017, Shane Bryant, 29; Rashan Charles, 20; Edson da Costa, 25; and Darren Cumberbatch aged 32, died following arrest. Newspaper reports suggest the official investigation into the death of Cumberbatch underplays the deterioration in his mental health whilst in contact with the police (*The Guardian*, 2017). As there was alleged use of force and Cumberbatch was taken to hospital with injuries, a referral should have been made immediately to the Independent Police Complaints Commission however this did not happen until 10 days later, by which time Cumberbatch had succumbed to his injuries. Cumberbatch and the three other men were black. These racialised deaths have continued despite the documented history – which when publicised are often portrayed as isolated incidents – of black people dying in forensic settings as a consequence of the use of force or restraint. Well

The International Handbook of Black Community Mental Health, 41–60

doi:10.1108/978-1-83909-964-920201004

documented is also the over representation of black people detained under the Mental Health Act yet underrepresented in community treatment such as counselling or therapy (Cabinet Office; Race Disparity Audit, 2017), indicating the lack of support and intervention preventing deterioration in the mental health of black people. Dyer (2017) suggests this is the country's 'dirty secret' that needs to be addressed.

I refer to 'black people' as those who identify their origins as Black British, Black Caribbean or Black African. Although Asian people face discrimination, they are not significantly disproportionally over represented in mental health or criminal justice statistics, which is the focus of this chapter. Still, many studies are not so discerning and do use the term Black and Minority Ethnic (BME) without making the distinctions between Black and Asian. However, these broader definitions are in line with that used in the government document Delivering Race Equality in Mental Health Care (Department of Health, 2005) which includes:

> all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants. (p. 11)

I also use the term racism as oppose to discrimination. Race is the basis for the oppressive behaviour based on colour or ethnicity whereas discrimination can occur on the basis of any type of perceived difference, for example, gender or disability. Stokely and Hamilton (1967) suggest 'By "racism" we mean the predication of decisions and policies on considerations of race for the purpose of subordinating a racial group and maintaining control over that group' (p. 20). My interest in the wellbeing of black people in the CJS is borne out of my experience as a black woman working within police custody suites in East London in the late 1990s, assessing people with mental health and substance misuse issues. This was followed by 10 years with HM Prison Service and National Offender Management Service as one of the few black female senior managers. I have subsequently developed my own thinking about the reasons for the over representation of black people with mental health issues and their experience in the CJS. Nonetheless, the process of writing this chapter has been an unexpected emotional toil. Reading report after report about black men who have been diagnosed with a mental illness, detained, injured and killed in twenty-first century Britain has been an emotional challenge. Knowing that this occurs at the hands of the police who have a duty to serve and protect and nursing staff that have a duty of care makes it even more appalling. The notion that successive governments have failed to implement recommendations from reviews and inquiries that might have saved lives is nothing short of diabolical. Despite the knowledge emergent from research, reports, reviews and recommendations, there is a continuance of the disproportionality faced by black people in mental health and CJS.[1]

[1] At the time of publication, COVID-19 had created a pandemic. The intensive care national audit office (2020) found one third of people stricken by the virus were BME, despite making up only 17% of the UK population. Similarly, in the US, 23% of the population in Cook County, Illinois are black yet 58% of COVID-19 deaths were of black people.

As I write I wonder what difference this chapter can make in the midst of the existing plethora of text that have failed to ignite a response from those with the power to end this phenomenon of what is essentially a legitimised racialisation of mental health and lawful killing of black men. That said, I continue, believing that I have a duty to contribute to the discourse until these experiences are no longer a 'dirty secret' which remain unresponded to. In this chapter my discussions focus largely on the experiences of black men as they are more likely than woman to encounter the phenomena of a mental health diagnosis, detention and death in a forensic setting. I will briefly explore reasons given by other researchers for the over representation of black people with mental health issues before offering my own theoretical interpretation which is a combination of systemic racism influenced by post-colonial conceptualisation.

Over-representation in Mental Ill Health and Custody

Sharpley, Hutchinson, McKenzie, and Murray (2001) note how after the large-scale migration of people from the Caribbean to the UK in the 1950s, only a decade later research indicated an over representation of those migrants being diagnosed with schizophrenia. To contextualise the scale of the over representation, Xanthos (2008) states that in any given country schizophrenia typically affects 1% of the population. Yet Hickling (2005) identified a 6- to 18-fold elevated rate of diagnosis amongst the black population in the UK. A larger scale study reported a year later found a ninefold increase in the risk of black people developing schizophrenia with an increased risk of 1.4 for South Asians when compared to the white British population (Fearon et al., 2006). Tortelli et al. (2015) found statistically significant higher incidence rates in the black Caribbean group, present across all major psychotic disorders, including schizophrenia and bipolar disorder. Stevenson and Rao (2014) found despite

> controlling for the social and economic factors known to influence wellbeing, there appears to be a residual, non-random difference – with people from Black and Minority Ethnic (BME) communities reporting lower levels of wellbeing than their White counterparts. (p. 12)

Since 2005, the Care Quality Commission conducted an annual census in relation to people from specific ethnic backgrounds experiencing mental ill health. Their last survey concluded that people from Ethnic Minorities remain disproportionately represented on mental health wards with no signs of this reducing (Care Quality Commission, 2011). The census identified that rates of hospital detention were between 19% and 32% above average for people with mental ill health from black Caribbean, black African and mixed white/black groups. This was two times higher than the average for 2010. Supporting these findings, the Health and Social Care Information Centre (2016) found Black or Black British people were the highest proportion of ethnic minority groups who had spent time in mental health hospitals in the year 2014/2015.

Self-isolation, illness, fear of death and increased risk of being stopped by police under the UK COVID-19 Bill will undoubtedly exacerbate the mental health of black people.

The over representation of mental ill health amongst black people also permeates throughout each juncture of the CJS. The Ministry of Justice (2015) state:

> In general, Black, Asian and Minority Ethnic (BAME) groups appear to be overrepresented at most stages throughout the CJS, compared with the White ethnic group … with little change in relative positions between ethnic groups. (p. 7)

Thornicroft (2006) found 10% of black patients in forensic settings have not committed a crime, they have been admitted to these units from general psychiatric wards. A decade later the European Commission against Racism and Intolerance Report (ECRI, 2016) noted an increase whereby black people are 50% more likely to be referred to the psychiatric services via the police than white people. Singh et al. (2014) argue that ethnicity acts as a predictor of the high levels of mental health detention amongst black people. A variety of reports and research demonstrate this point. For example, the Bradley report (2013) identified

> BME communities are 40% more likely than White Britons to access mental health services via a CJS gateway (Bradley, 2009). Black people, in particular, are more likely to experience higher compulsory admission rates to hospital, greater involvement in legal and forensic settings and higher rates of transfer to medium and high security. (p. 4)

The findings from the Bradley report echo what was reported 10 years prior in the Bennett Inquiry (2003). They reported that black patients are more likely to be restrained, more likely to be secluded and more likely to be prescribed medication than any other group. These patients are also less likely to be given psychological treatment rather than physical treatment. Fitzpatrick, Kumar, Nkansa-Dwamena, and Thorne (2014) noted

> The most egregious inequalities in mental health care continues to be the overrepresentation of black men at the 'hard end' of services at point of arrest, in prison and within secure treatment. In its most extreme form this is represented by repetition of deaths in custody under restraint. (p. 8)

INQUEST (2015) suggests deaths of people in mental health detention make up 60% of the overall death in any type of custodial setting. They posit the high incidence of these deaths are amongst black people and are concerned that institutional racism is a contributory factor.

Findings from INQUEST's casework demonstrate the disproportionate number of people from BME communities die in or after detention in police custody following the use of force. From 1990 to 2017 there have been a total of 94 BME deaths in police custody, 13 of which have been shootings within the Metropolitan Police Service. In other constabularies in England and Wales there have been

76 BME deaths; three of which have been shootings. During the same period there have been 247 self-inflicted BME deaths and 203 non- self-inflicted deaths (excluding natural deaths) in prisons in England and Wales (INQUEST, 2017). The Angiolini Report confirmed

> The Government has acknowledged that there is 'significant over-representation of Black, Asian and minority ethnic (BAME) individuals in the criminal justice system' and that 'disproportionate number of people who have died following the use of force were from BAME communities'. (p. 84)

The combination of these statistics demonstrates the over represented of black people in relation to mental health, the CJS and the likelihood of death (excluding natural causes) when in the CJS. A variety of reasons for this racialisation of mental health have been offered by different researchers.

Reasons for Over Representation

Sharpley et al. (2001) found theories explaining the reasons for increased rates of black people diagnosed with mental health issues ranged from genetic predisposition, migration factors, cannabis use, social disadvantage to racism. Singh et al. (2014) suggest racial discrimination still remains the most studied variable in mental health disadvantage for Black Caribbean's. Alarcon (2009) argues the cultural needs of black people and their behaviour is misunderstood and misinterpreted, resulting in misplaced diagnosis. Comparison studies have been conducted in attempt to support or contest this theory. Studies have looked at the rates of mental health diagnosis of black people in their country of origin, compared to the rates of black people in the UK who have a mental health diagnosis. For example, Hickling and Rodgers-Johnson (1995) looked at the incidence of schizophrenia in Jamaica, Bhugra et al. (1996) focussed on Trinidad and Mahy, Mallett, Leff, and Bhugra (1999) looked at Barbados. Each found the rate of schizophrenia in the respective country was equitable to the incidence of schizophrenia amongst the British white population in the UK. Thus, the over representation could be concluded as being connected to a phenomenon experienced by black people once they arrive or are born in the UK. Hickling, McKenzie, Mullen, and Murray (1999), a Jamaican psychiatrist and his colleagues examined the same patients as his white counterparts yet they only agreed on the diagnosis of 55% of cases. Still, other research has suggested the over representation is not necessarily due to a cultural misdiagnosis. For example, Fung, Jones, and Bhugra (2009) found that factors such as age, sex, socioeconomic status, social isolation, genetic factors, infections, stress, substance misuse and discrimination, appeared to be related to the over representation. These factors tended not to have been accounted for in the early research of the 1960s and 1970s, largely as a consequence of poor patient record keeping and inadequate methodology in the research (Pinto, Ashworth, & Jones, 2008; Tortelli et al., 2015). However, there has since been much support for

the notion that the experiences of racism and discrimination increase the risk of mental ill health within the black community. Bhui et al. (2005) identified a strong association between perceived discrimination in the workplace by black people and the development of mental health disorders. Pinto et al. (2008) posits a combination of isolation and exclusion, both within society and within the family, contributes to the incidence mental ill health in black people. However, they concluded racism itself may contribute to social exclusion, increasing the vulnerability to schizophrenia. The ECRI noted the allegations of discrimination that black people have made against the police and by the mental health services. ECRI suggest high levels of coercion rather than care typify the black patient experience. The Black Manifesto (2010) found 40% of patients in Broadmoor, Ashworth and Rampton high security psychiatric hospitals were of African-Caribbean origin and the average stay for these patients was more than nine years, longer than the stay of white patients.

Big, Bad and Dangerous

Rather than the behaviour of black people being misunderstood and misinterpreted resulting in misplaced diagnosis, there is also an ideology that a stereotype of black men being big, bad and dangerous pervades the mental health and CJSs with the consequence of higher rates of schizophrenia attributed particularly to black men. The Angiolini Report (2017) argues

> The stereotyping of young Black men as 'dangerous, violent and volatile' is a longstanding trope that is ingrained in the minds of many in our society. People with mental health needs also face the stereotype of the mentally ill as 'mad, bad and dangerous'. (p. 88)

The construction of the black man as 'big, bad and dangerous' is not only dehumanising, but creates the risk of over use of force when those who have the power to retrain is seeing a vulnerable and mentally ill man as a threat. The report further states

> It is not uncommon to hear comments from police officers about a young Black man having 'superhuman strength' or being 'impervious to pain' and, often wholly inaccurately, as the 'biggest man I have ever encountered'. Such perceptions increase the likelihood of force and restraint being used against an individual who may be unwell. The detainee is effectively dehumanised. (Angiolini Report, 2017, p. 88)

The notion of 'Big, bad and dangerous' is not new. It was evident in the case three black men who died in the 1980s and 1990s whilst detained in Broadmoor. The three men of concern were Michael Martin who died in 1984, Joseph Watts died in 1988 and Orville Blackwood died in 1991 following the use of restraint and the forcible injection of tranquillising medication. All three had a diagnosis

of schizophrenia (INQUEST, 2015). The Special Hospital Service Authority (SHSA, 1993) was tasked to investigate the circumstances of Blackwood's death and review the circumstances of the deaths of Martin and Watts. Crichton (1994) states the impression given of these men during the inquiry by staff at Broadmoor was that they were 'big, black and dangerous' so much so the committee investigating Blackwood's death used the phrase in the title of their report. The stereotype of the black male with mental health issues continues to exist. The Angiolini Report (2017) notes that during the review into the death of Sean Rigg in 2008 after being restrained by police, an officer described Rigg's behaviour as possibly related to mental health, but also 'other reasons, especially with people you come across in Brixton' (p. 87). The reference to Brixton (in Lambeth, South London) appears to have been in regarding the 26% black population and assumptions about smoking cannabis. The Independent Inquiry into the death of David 'Rocky' Bennet who died in 1998 in a secure psychiatric hospital after being restrained stated

> Psychiatrists sometimes make a diagnosis of 'drug induced psychosis' which, as far as African-Caribbean's are concerned, nearly always relates to the use of cannabis. There appears to be no clear medical basis for this diagnosis. (Norfolk & Cambridgeshire Strategic Health Authority, 2003, p. 41)

As such, when a psychiatrist makes a diagnosis based on a stereotype there is the risk that this misdiagnosis will lead to the wrong treatment. The Angiolini Report (2017) also stated 'racial stereotyping needs to be investigated within the context of a wider picture of related deaths and non-fatal incidents where race may have been a factor' (p. 87). Coupled with the racial stereotyping is the lack of response to the recommendations made in reports to change process that are related to the deaths of these men.

Inertia Following Inquires

Despite the racialised stereotype, Cummins (2015) notes the inquiries into Martin and Watts concluded that there was 'no direct evidence of racism at Broadmoor' (p. 16). Yet, the SHSA inquiry contested this and stated that staff and management did not seem to appreciate how subtle forms of racism operate. Crichton reports the inquiry found *by omission* (my emphasis) a racial institutional bias against ethnic minorities. The inquiry identified there was no equal opportunities policy, no statistics kept on the numbers of black patients and a colour-blind approach was taken which ignored the issues of black patients. The report states 'The experience of Afro-Caribbean inner-city youngsters is not fully understood by Eurocentric psychiatry and those who work in the psychiatric system. It is important that differences are recognised and catered for' cited in Crichton (1994). Several years later, the review into the death of Sean Rigg as referred to in the Angiolini Report (2017) raised comparable concerns regarding the race blind approach. It stated

> The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately. (p. 88)

The 'malaise' mentioned continues regarding the recommendations in the Blackwood inquiry. Crichton and Sheppard (1996) highlight the inquiry team requested to be reassembled to consider how their recommendations were being followed up. The SHSA did not invite them back; it was later recognised there was an 'absence of any formal procedure for follow up of those recommendations or explanation for their non-implementation' (Downham & Lingham, 2009, p. 63). An absence of action was noted in the Bennett Inquiry about issues raised in the SHSA (1993) report into Blackwood and the issues emerging from the Bennett Inquiry (Norfolk & Cambridgeshire Strategic Health Authority, 2003):

> that Inquiry also wrote a chapter on the problems of racism which contains information on many of the general matters that we have heard during the course of this Inquiry and set out in this report. While we recognise that it takes time to implement reforms and to act upon recommendations, we express our grave concern at the apparent lack of reaction by anybody in authority to attempt to implement these and other recommendations made in that report. (p. 63)

The Bennett Inquiry also identified the needs of black patients were not adequately met and the issues they highlight in the report had been known to the National Health Service (NHS) for years. The following is a summary of black people who died whilst in psychiatric custody. The list is taken from The Institute of Race Relations, and includes those who died following the death of Orville Blackwood in 1991 until the Inquiry into David Rocky Bennett in 2003:

- *28/8/91 Orville Blackwood (31)*. Orville was found dead in a secure unit of Broadmoor top security hospital after being given a tranquilliser injection.
- *8/1/92 Mark Fletcher (21)*. Mark was detained by police and then sectioned under the Mental Health Act and transferred to a Psychiatric hospital where collapsed after being restrained and given an injection into his spine.
- *6/92 Munir Yusef Mojothi (26)*. Munir was a psychiatric patient, he was given an injection of droperidol and then transferred to Clifton hospital, where he was given another injection and an intravenous dose of the drug was given by a doctor.
- *23/6/92 Jerome Scott (27)*. Jerome collapsed and died on his way to hospital in a police van. Two psychiatrists administered an intravenous injection. Jerome was held down by police and then injected with two different anti-psychotic drugs.
- *30/1/94 Rupert Marshall (29)*. Rupert died in Horton psychiatric hospital, Epsom after being restrained and injected with an anti-psychotic drug.

- *10/8/94 Jonathan Weekes*. Jonathan died in hospital, he had depression. It was later revealed that Jonathan was receiving eight different drugs this information was not available to the inquest.
- *30/10/1998 David 'Rocky' Bennett*, restrained by four nurses for over 30 minutes.

The Institute of Race Relations (2004) interviewed Richard Stone, member of the Bennett Inquiry panel, he stated:

> If the government does not respond to our recommendation that they acknowledge institutional racism in the mental health service they will get away without doing anything. Furthermore, my concern is that there will be more deaths resulting from restraint in the prone position unless recommendation nine – the three-minute time limit for such restraint – is implemented as a matter of urgency. We can't wait for more research. (p. 1)

Delivering Race Equality (2005) was a five-year action plan established the government following the Bennett Inquiry. The aim was to address these deep-seated race related issues and produce services that were more sensitive to the black community. However, this failed to happen and the initiative was abandoned with many of the recommendations outstanding. The roll call of black people who died between Blackwood and Bennett may not have been as extensive if some of the recommendations had been implemented. MIND (2013) conducted research into the number of deaths due to the use of restraints, they state,

> Shockingly, since Rocky Bennett's death there have been at least 13 restraint-related deaths of people detained under the Mental Health Act 1983. Eight of these occurred in a single year (2011). More than 15 years since Rocky Bennett's death, we are still no closer to implementing the lessons learned from his death and people are still dying as a result of physical restraint. (p. 3)

The MIND (2013) report further noted

> It is totally unacceptable that the lessons learnt as a result of the tragic deaths of Orville Blackwood, Michael Martin, Joseph Watts and David Bennett continue to be ignored and people using mental health services still remain at high risk of injury and even death as result of the use of physical restraint. (p. 4)

Following the failure of Delivering Race Equality (2005), other national initiatives aimed to address racial inequalities such as the Mental Health Task Force (2015) and The Ministerial Advisory Group on Mental Health Strategy (2017) have been set up. These national initiatives have coexisted alongside local initiatives such Lambeth Black Health and Wellbeing Commission, formed

following the death of Sean Rigg. The Commission found 26% of the population in Lambeth was from African or Caribbean descent, yet 70% of the residents in secure psychiatric settings in the area were black (2014). Despite these national and local schemes – many of which only last the lifespan of a government term in office – statistics from the Race Disparity Audit (2017) demonstrate little has changed for the plight of black people. This raises important questions regarding why successive governments have failed to nationally implement the recommendations from these inquiries despite the number of deaths that continue to occur. It also raises questions about how these (mainly) black men have been constructed as big, bad and dangerous, diagnosed with schizophrenia, held in forensic mental health settings and detained longer than their white counterparts or killed. Many would argue it is a result of institutionalised racism but I contend this provides only a partial explanation.

Why Institutional Racism is Not the Answer

Institutional Racism is the term often used to explain racism that is inherent in institutions. The term was defined by Stokely and Hamilton (1967) with reference to racism in America.

> Institutional racism refers to particular and general instances of racial discrimination, inequality, exploitation, and domination in organisational or institutional contexts, such as the labour market or the nation-state. (p. 3)

However, the term was not widely introduced into discourse in England until over 30 years later when the Home Office (1999) inquired into the racially motivated murder of Stephen Lawrence. The chair of the inquiry, William Macpherson then defined Institutional Racism as:

> […] the collective failure of an organisation to provide an appropriate or professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people. (para 6.34)

When unpicking Macpherson's definition, there are a number of points to consider. The phrase, 'the collective failure of an organisation' indicates no-one is at fault or is accountable for the racism that exists in the organisation or institution. As a collective failure, it can be assumed that a collective response is required for change. This itself is problematic as it averts liability from those leading the organisation who ultimately have decision-making powers on how the institution is run, what is permissible, what policies are in place and the sanctions for not adhering to those policies.

Souhami (2012) questions if the term Institutional racism works conceptually as an instrument for change. She argues:

> While the concept provoked an urgent reaction, its central ambiguities confronted police services with profound difficulties in responding … it inadvertently focused attention on internal police culture. Consequently, despite the Inquiry's intention that the term would divert attention away from a preoccupation with overt racism among police staff, this is precisely where reform activity was directed. (p. 1)

Souhami (2012) goes further to suggest that 'the concept not only failed to direct attention to the dynamics of institutional discrimination but, through the activity it elicited, in fact sustained them' (p. 1). I contend the problem is sustained *in part* due to individuals not being found culpable for their racist actions. Stokely and Hamilton (1967) note racism takes two forms: individual and institutional. They argue that institutional racism is more subtle and covert and as it originates within recognised institutions in society. However, Deloria (1982) argues the institution should be seen as having the personality – or what I understand as organisational culture – and suggests this is what needs to change. He states that attempts to change individual are futile 'personality substantially affects how individual members of the institution respond to external phenomena, and not the other way around' (Deloria, 1982, p. 51). However, the task to change becomes more complex when the institution claims to be unaware of the racist and discriminatory culture. Macpherson's definition refers to 'discrimination through unwitting prejudice'. The word 'unwitting' suggests the racism is emanating from a place of unknowing or unintentionality, further excusing the individuals and institution from responsibility. Paradies, Bastos, and Priest (2016) suggests the concept of bias is often referred to within health care contexts to describe unconscious forms of discrimination, known as implicit bias. My concern is the extent to which racist behaviours are excused as unwitting, ignorance, thoughtlessness implicit bias, which all contribute to the perpetuation of racism but without accountability. The Independent Inquiry into the death of David Bennett (2003) stated 'there was a real difference between unconscious misunderstanding and deliberate racism' (p. 23). I would suggest much of the construction of the big, bad and dangerous black man that went on with staff in the mental health services was *conscious* racist stereotyping. Cummins (2015) argued that patients such as Blackwood had the insight to believe his period in detention was extended due to racist stereotyping not because his mental health justified it (p. 17). Blackwood was detained in Broadmoor for a significantly longer period than if he had been detained in prison for his original offence. The stereotype of him being big, bad and dangerous fed into how he was perceived, treated and ultimately killed. Cummins (2015) argues that 'Psychiatry, along with the CJS agencies has played a key role in creating the racist stereotype of the psychically aggressive violent black male' (p. 22). Here Cummins is clearly asserting the institutions – medical as in psychiatry and

the CJS –are at fault without holding the individuals who created and perpetuated the stereotypes to account. I am not arguing that institutional racism is the single reason for the over representation of black people with diagnosed as schizophrenic, or the over representation of black people with mental health issues in the CJS, or why more black people than any other racial group die whilst detained. Rather I am arguing that systemic racism provides a more adequate explanation for these phenomena.

Systemic Racism

'Deaths of people from BAME communities, in particular young Black men, resonate with the Black community's experience of systemic racism'. Angiolini Report (2017, p. 84). The report espouses the term 'systemic racism' diverging from the expression 'Institutionalised racism' but no definition of systemic racism is offered. Feagin (2001) provides us with a discourse relating to systemic racism in America. He posits a meaning of systemic racism whereby

> Systemic racism includes the complex array of anti-black practices, the unjustly gained political economic powers of whites, the continuing economic and other resource inequalities along racial lines and the white racist ideologies and attitudes created to maintain and rationalise white privilege and power. Systemic here means that the core racist realities are manifested in each of societies major parts … the economy, education religion, the family – reflects the fundamental reality of systemic racism. (p. 6)

Feagin (2006) proposes that systemic racism becomes embedded in each aspect of society and perpetuated by social processes that reproduce not only racial inequality but also the fundamental racist relationship between the racially oppressed and the racial oppressors. Feagin suggests these processes are historical and can be traced back to slavery when the relationships between the oppressors (privileged white people) and the oppressed (black people) began. He identifies various points in American history post-slavery and post-segregation to demonstrate how embedded systemic racism is and continues to be in society. I consider myself a systemic thinker; seeing through a systemic lens (Von Bertalanffy, 1968). Campbell (2000) explains:

> Systemic thinking is a way to make sense of the relatedness of everything around us. In its broadest application, it is a way of thinking that gives practitioners the tools to observe the connectedness of people, things and ideas; everything is connected to everything else. (p. 7)

The concept of connections are inherent in Feagins argument of systemic racism and are aligned with the phenomena in England experienced by black men in the criminal justice and mental health systems. The connection between

the people who are killed by restraint is that they are black men seen as big, bad and/or mad and dangerous. The institutions they die in namely forensic mental health or criminal justice are connected; often black men are referred from a criminal justice setting into a secure mental health setting. There are similarities in the circumstances surrounding their death. There is a pattern in the process following their death; an inquiry, recommendations are made and ignored and initiatives are abandoned. Another death takes place and the pattern repeats itself. Von Bertalanffy (1968) discussed how general systems seeks to maintain an equilibrium by a continuous inflow and outflow, a building up and breaking down of components, where patterns are repeated to achieve a steady state. From a systemic perspective, the same is true of human systems which strive to maintain a balance, equilibrium or the status quo in society and between interpersonal relationships. Not everyone within the system may benefit from the equilibrium state, however, whilst the majority does benefit or is at least not disadvantaged, the system will continue to reproduce itself in the same way. To understand how Feagin's position relates not only to systemic racism in America but also to England is to understand the parallels between countries in that there is a culture of privileges associated with 'whiteness' and disadvantages associated with being black that is traced back to slavery and colonialism. I will use the example of the historical relationship between England and Jamaica, where my parents migrated from, to explore the longstanding culture of racism, disadvantage and the relationship between the oppressor and oppressed which Feagin speaks of.

Colonisation; Native, Object and Possession

Jamaica became a British Colony when the country was seized from Spain in 1655. The colonisation became formal in 1670, when the Treaty of Madrid (also known as the Godolphin Treaty) was signed. The treaty decreed that Spain recognised *English Possessions* in the Caribbean Sea 'all those lands, islands colonies and places, whatsoever situated in the West Indies' (National Humanities Centre, n.d., p. 6). Immediately what comes to my mind is Jamaica as an *object* to be fought over while the word *possession* dehumanises the people who inhabit the country. Jamaica became one of the biggest slave markets and slave destinations in the world to provide a slave trade meeting the labour force required to extract sugar from sugarcane. This exemplifies the beginning of the relationship between the oppressor and the oppressed.

With the abolition of the slave trade, Britain sent migrants of colour importing workers from China and India (1850–1866) – then a British Colony – under contracts of indenture to support the workforce which had become depleted by the loss of slavery. However, living and working conditions were not much better than when people were enslaved, therefore the Chinese Government brought their citizens out of the indentured contracts (Rajkumar, 2013). For the Indians and Jamaicans colonised by the British, they had little option but to remain. World War I brought with it the prospect of being a paid soldier, therefore my grandfather was one of the 10,280 men from Jamaica to volunteer to join the British

West Indies Regiment (BWIR), segregated from white soldiers. The SS Verdala transported soldiers from Jamaica during March 1916, inadequate clothing and heating resulted in more than 600 soldiers suffering from exposure and frostbite leaving 106 men to have amputations (Bourne, 2014). The training camps in England had substandard accommodation whereby men from the BWIR developed further frostbite and pneumonia. In addition to this, the soldiers were initially denied a pay rise given to other British troops on the basis they were classified as natives (Peatfield, n.d.). By the end of war, almost as many black men had died from illness; 1,071 as had died in action; 1,185 (Peatfield, n.d.). This demonstrates the lack of value placed on the life of the black soldier, not perceived as equal to that of their white counterparts; viewed as 'native'.

Following the destruction from World War II and the need for nurses to work in the newly established National Health Service (NHS) the British Nationality Act (1948) was introduced to permit residents of British Colonies to become British Citizens, and work in unskilled jobs. My parents arrived in England 1961, the last flurry of migrants to enter the country in anticipation of the 1962 Commonwealth and Immigration Act. The Act aimed to restrict the number of migrants coming to Britain as there were by then sufficient numbers to address the labour shortage. Additionally, the visual presence of black people in England was upsetting the equilibrium and racially motivated violence had started to occur (Pilkington, 1988). It is no coincidence that Jamaica also gained its' independence in 1962, uncoupling Britain from any responsibility to the Jamaican nationals who were experiencing high unemployment. These events from slavery through to colonisation demonstrate the differential power relations between black and white people and the embedded systemic racism that has continued to pervade throughout British society.

Postcolonial Theory – The Legacy

Postcolonial Theory reminds us that the ramifications of colonialism can remain inherent in a country in terms of economic stability, culture and national identity and continue to experience the reverberations in the postcolonial age (Walker, 2017). Hall (1996) posits how Postcolonial theory provides an understanding of culture and identity as fluid, contested, deconstructed and reconstructed. The theory suggests Postcolonial structures become reproduced in everyday life (Routledge 2016). Fernando (1991) argues how racism informed the diagnostic categories used by psychiatrists in America during the period of slavery sighting the example of proto-psychiatrist Cartwright (1851), who diagnosed the 'madness' of slaves who ran away from their owners. More recently, Metzl's (2009) identified African American protestors during the civil rights movement were diagnosed with schizophrenia. These are examples of how black people have been disempowered and socially abused when they exercise their right to be free from oppression. This brings me to the phenomena we are experiencing in Britain today. As I have argued, institutional racism is only a partial and inadequate explanation of the phenomena experienced by black men in Britain.

Systemic Racism Explanations

I have identified examples from England of the historical systemic racism Feagin (2001, 2006) suggests is steeped in America's history. I suggest England has a parallel legacy that has emerged from an oppressive, colonial mindset, passed through generations, institutions, organisations, legislation via a combination of racial bias, stereotyping, dsyconscious racism, overt racism, omission of equity resulting in the maintenance and has been maintained in England. Firstly, colonisation and slavery have provided Britain with a culture of ownership of 'other'. The relationship between the England and the colonised country and the relationship between the people is immediately one exemplified by the dualisms of power/powerless, oppressor/oppressed, privilege/disadvantage. From a systemic perspective, the equilibrium has been established by these dichotomies which continue to reproduce themselves centuries after the abolition of slavery and decades after a country ceases to be colonised. The threat to this balance would be complete equality between the countries and the people who inhabit them. I have noted examples of where a diagnosis of mental health has been applied to run away slaves and civil rights protestors. These black people have challenged the status quo and attempted to re-balance the existing equilibrium where black people are disadvantaged or oppressed. The mental health diagnosis serves to punish and discredit the behaviour undesired by the privileged white community and prevent the punished black people from influencing the wider black community. It also serves to generate fear in the wider community that this will be the consequences for contesting oppression.

The over representation of black men in both the criminal justice and mental health systems also serve to maintain the equilibrium of oppressor/oppressed, privilege/disadvantage. When a black man is dehumanised in the construction of the big, bad and dangerous stereotype, there is a reticence by those in power to address his misdiagnosis or killing. Being perceived as superhuman and dangerous, the justification for being restrained and/or killed is to preserve the safety of others. As such, the risk to others is perceived as too great to implement recommendations that might change the status quo. Although the overt rational may be related to safety, the covert and underlying reason for the disproportionate imprisonment, restraint and death is a demonstration of white power and the devaluing of black lives. It shows that white power pervades throughout society and black people should fear the extent of this power. The unlawful killing as a result of restraint may just as well be seen as the modern version of lynching.

I struggled for weeks to draw this chapter to a close. It was a difficult chapter to write from the outset, yet somehow, I could not find the words to bring it to an end. That is until I was confronted with a situation similar to what I have been writing about. I was teaching a class of social work students, I had been teaching them all day so by the afternoon I was relaxed, I had kicked off my shoes and enjoying the interaction with them when a white man appeared at the door. He entered without knocking and was followed by two other white men. The class I was teaching were 95% black students; the presence of three white men standing in the room was domineering. The first white man spoke and said he did not want

to disturb the class, but there had been an altercation, he was head of security and he was looking for the student involved. Rather than speak to me privately, this was said as an announcement to the class. I was stunned. I scanned the room puzzled thinking who would have had an altercation – and *when*? He walked over to a black, male student at the back of the room and said come with me; the doorway now flanked by the other two white men. I ran out after them in my stockinged feet, fearful of what was happening to my student. Surrounded by these three white men, my student was accused of being threatening and aggressive to a female student. He looked as shocked as I was at the allegations. Immediately I thought of Orville Blackwood, Rocky Bennett and the others that were killed. I could see the scene being replayed in front of me; a black man has an 'altercation' with someone white, the black man is reprimanded, in the process of defending himself he is accused of being aggressive, he is restrained and killed.

My student was trying to explain what had taken place, the white man was insisting he needed to listen. I heard words such as 'aggressive', 'threatening' and 'investigation'. I knew what the student or I said in the next few minutes could mean the difference between life or death – literally. I touched my student's arm and told him not to speak; for the moment just listen. I said we needed to move this out of the corridor into a private space. Still without my shoes, I led my student and the white man into a nearby office. I tried to put the 'altercation' into context. The situation began to defuse to whereby the white man concluded there was in fact no threat and he would draw the matter to a close. As soon as he left I burst into tears. I was so angry I could not speak. I had been scared for my students' life. That might seem an over-reaction to anyone unaware that black men in similar situations have ended up being restrained and killed. On one hand I felt guilty for silencing my student – who is an adult, a father and husband – but I was *afraid* the situation could escalate to where the police were called and I would have a dead student stereotyped as big, bad and dangerous. I felt I had compromised myself and my student rights by advising him to wait before speaking. Yet, this is what I believed I had to do for him to stay safe. In terms of the university hierarchy, I was absolutely higher ranked than this white man but my power was precarious and changeable depending on the situation (Hill-Collins, 1990). If the police were called my power would be completely diminished. This is the legacy of colonialism, oppression, disadvantage and being viewed as other. Knowing that black men are disproportionately imprisoned, sectioned under the Mental Health Act or killed made me fearful. I was scared for my students' life. Yet, this is the *purpose* for these disproportionalities; it sends a clear warning and a sense of fear to those in the black community that are aware of these 'dirty secrets' not challenge those in power. This is how the duality of oppressor/oppressed and privileged/disadvantage remains.

Understanding systemic racism is not enough to change it, however, it is a start to have this awareness. Also to recognise it is futile to expect those that benefit from the power imbalance to be the ones to implement recommendations that would diminish the power they have. Therefore, change will only happen when the black community becomes mobilised and united to overcome individual fears and begin to influence the institutional culture across the institutions where systemic racism has been reinforced.

References

Alarcon, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: Review and projections. *World Psychiatry*, *8*(3), 131–139.

Angiolini, E. (2017). Report of the independent review of deaths and serious incidents in police custody. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

Bhugra, D., Hilwig, M., Hossein, B., (1996). First-contact incidence rates of schizophrenia in Trinidad and one-year follow-up. *British Journal of Psychiatry*, *169*, 587–592.

Bhui, K., Stansfeld, S., McKenzie, K., Karlsen, S., Nazroo, J., & Weich, S. (2005). Racial/ethnic discrimination and common mental disorders among workers: Findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom. *American Journal of Public Health*, *95*(3), 496–501. http://doi.org/10.2105/AJPH.2003.033274

Bourne, S. (2014). *Black Poppies: Britain's black community and the great war*. London: The History Press.

Bradley. (2009). *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: House of Lords.

Cabinet Office. (2017). Race disparity audit. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/650723/RDAweb.pdf

Campbell, D. (2000). *The socially constructed organisation*. London: Karnac.

Care Quality Commission. (2011). Count me in census. Retrieved from http://www.cqc.org.uk/news/releases/care-quality-commission-looks-ahead-last-count-me-census-published. Accessed on March 9, 2017.

Crichton, J. (1994). Comments on the blackwood inquiry. *Psychiatric Bulletin*, *18*, 236–237. doi:10.1192/pb.18.4.236.

Crichton, J., & Sheppard, D. (1996). Psychiatric inquiries: Learning the lessons. In J. Peay (Ed.), *Inquiries after homicide* (pp. 65–78). London: Duckworth.

Cummins, I. D. (2015). Discussing race, racism and mental health: Two mental health inquiries reconsidered. Retrieved from http://usir.salford.ac.uk/35493/

Deloria, V. (1982). Institutional racism. *Explorations in Ethnic Studies*, *5*(1), 40–51.

Department of Health. (2005). 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. Retrieved from http://webarchive.nationalarchives.gov.uk/20130123204153/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773. Accessed on October 14, 2017.

Downham, G., & Lingham, L. (2009). Learning lessons: Using inquiries for change. *Journal of Mental Health Law*, 57–69. Retrieved from www.northumbriajournals.co.uk/index.php/IJMHMCL/article/download/281/275

Dyer, J. (2017). Jacqui Dyer: Talking about race and mental health is everyone's business. Retrieved from https://www.theguardian.com/society/2017/nov/08/jacqui-dyer-race-mental-health-act-black-people-detentions-inequality

European Commission against Racism and Intolerance Report. (2016). ECRI. Retrieved from https://www.coe.int/t/dghl/monitoring/ecri/Country-by-country/United_Kingdom/GBR-CbC-V-2016-038-ENG.pdf

Feagin, J. R. (2001). *Racist America: Roots, current realities, and future reparations*. New York: Routledge.

Feagin, J. R. (2006). *Systemic racism: A theory of oppression*. Routledge/Taylor & Francis Group.

Fearon, P., Kirkbride J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., … & AESOP Study Group. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC ÆSOP Study. *Psychology Medicine*, *36*(11), 1541–1550.

Fernando, S. (1991). *Mental health, race and culture*. Basingstoke: Macmillan/Mind.
Fitzpatrick, R., Kumar, S., Nkansa-Dwamena, O., & Thorne, L. (2014). Ethnic inequalities in mental health: Promoting lasting positive change report of findings to LankellyChase Foundation. Retrieved from https://lankellychase.org.uk/wp-content/uploads/2015/07/Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf
Fung, W. L. A., Jones, P. B., & Bhugra, D. (2009). Ethnicity and mental health: The example of schizophrenia and related psychoses in migrant populations in the Western world. *Psychiatry*, *8*(9), 335–341. doi:10.1016/j.mppsy.2009.06.002
Hall, S. (1996). Introduction: Who needs identity? In S. Hall & P. Du Gay (Eds.), *Questions of cultural identity* (pp. 1–17). London: SAGE Publications.
Hickling, F. W. (2005). The epidemiology of schizophrenia and other common mental health disorders in the English-speaking Caribbean. *Pan American Journal of Public Health*, *18*(4–5), 256–262.
Hickling, F. W., McKenzie, K., Mullen, R., & Murray, R. (1999). A Jamaican psychiatrist evaluates diagnosis at a London psychiatric hospital. *British Journal of Psychiatry*, *175*, 283–285.
Hickling, F. W., & Rodgers-Johnson, P. (1995). The incidence of first contact schizophrenia in Jamaica. *British Journal of Psychiatry*, *167*, 193–196.
Hill-Collins, P. (1990). *Black feminist thought: Knowledge, consciousness and the politics of empowerment*. Boston, MA: Unwin Hyman.
Home Office. (1999). *The Stephen Lawrence inquiry. Report of an Inquiry by Sir William Macpherson of Cluny*. London: Stationery Office. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf
INQUEST. (2015). Deaths in mental health detention Feb 2015. Retrieved from http://inquest.org.uk/pdf/INQUEST_deaths_in_mental_health_detention_Feb_2015.pdf
INQUEST. (2017). BAME Deaths in police custody, Retrieved from https://www.inquest.org.uk/bame-deaths-in-police-custody
Institute of Race Relations. (2004). Rocky Bennet: Killed by institutional racism? Retrieved from http://www.irr.org.uk/news/rocky-bennett-killed-by-institutional-racism/
Lambeth Black Health and Wellbeing Commission. (2014). From surviving to thriving. Retrieved from http://lambethcollaborative.org.uk/wp-content/uploads/2014/08/ENC-4.4-BHWB-Commission-Final-Report2-PDF-June-2014.pdf
Mahy, G. E., Mallett, R., Leff, J., & Bhugra, D. (1999). First-contact incidence rate of schizophrenia on Barbados. *British Journal of Psychiatry*, *175*, 28–33.
Mental Health Task force. (2015). Terms of reference. Retrieved from https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/10/mh-tor-fin.pdf
Metzl, J. (2009). *The protest psychosis: How schizophrenia became a black disease*. Boston, MA: Beacon Press.
MIND. (2013, June). Mental health crisis care: Physical restraint in crisis. A report on physical restraint in hospital settings in England. Retrieved from https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf
Ministerial Advisory Group. (2017). Ministerial advisory group on mental health strategy. Retrieved from https://www.gov.uk/government/groups/ministerial-advisory-group-on-mental-health-strategy#terms-of-reference
Ministry of Justice. (2015). Statistics on race and the criminal justice system 2014: A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480250/bulletin.pdf
National Humanities Centre. (n.d.). Retrieved from http://nationalhumanitiescenter.org/pds/amerbegin/power/text1/SpanishEnglishRivalry.pdf. Accessed on November 15, 2015.

Norfolk, S., & Cambridgeshire Strategic Health Authority. (2003, December). *Independent inquiry into the death of David Bennett*. Cambridge. Retrieved from https://www.blink.org.uk/docs/David_Bennett_report.pdf

Paradies, Y., Bastos, J., & Priest, N. (2016). Prejudice, stigma, bias, discrimination, and health. In C. Sibley & F. Barlow (Eds.), *The Cambridge handbook of the psychology of prejudice* (Cambridge Handbooks in Psychology, pp. 559–581). Cambridge: Cambridge University Press. doi:10.1017/9781316161579.025

Peatfield, L. (n.d.). The story of the British West Indies regiment in the First World War. Retrieved from http://www.iwm.org.uk/history/the-story-of-the-british-west-indies-regiment-in-the-first-world-war

Pilkington, E. (1988). *Beyond the mother country: West Indians and the Notting Hill white riots*. London: Tauris.

Pinto, R., Ashworth, M., & Jones, R. (2008). Schizophrenia in black Caribbean's living in the UK: An exploration of underlying causes of the high incidence rate. *The British Journal of General Practice*, *58*(551), 429–434. http://doi.org/10.3399/bjgp08X299254

Rajkumar, F. (2013). The Chinese in the Caribbean during the colonial era. In R. Cruse & K. Rhiney (Eds.), *Caribbean atlas*. Retrieved from http://www.caribbean-atlas.com/en/themes/waves-of-colonization-and-control-in-the-caribbean/daily-lives-of-caribbean-people-under-colonialism/the-chinese-in-the-caribbean-during-the-colonial-era.html

Routledge. (2016). Critical race and postcolonial theory. Social theory re-wired. Retrieved from http://routledgesoc.com/profile/critical-race-and-postcolonial-theory

Sharpley, M., Hutchinson, G., McKenzie, K., & Murray R. (2001). Understanding the excess of psychosis among the African-Caribbean population in England: Review of the current hypothesis. *British Journal of Psychiatry*, *178*(Supplement 40), 60–68.

Singh, S., Burns, T., Tyrer, P., Islam, Z., Parsons, H., & Crawford, M. (2014). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*, *44*(5), 997–1004.

Souhami, A. (2012). Institutional racism and police reform: An empirical critique. *Policing and Society*, *24*(1), 1–21.

Special Hospitals Service Authority (SHSA). (1993). *Report of the Committee of Inquiry into the death in Broadmoor Hospital of Orville Blackwood and a Review of the deaths of Two other African- Caribbean patients, Big, Black and Dangerous*. London: SHSA (Chairman Professor H. Prins).

Stevenson, J., & Rao, M. (2014). *Explaining levels of wellbeing in Black and Minority Ethnic populations in England*. London: University of East London, Institute of Health and Human Development. Retrieved from http://hdl.handle.net/10552/3867. Accessed on August 30, 2017.

Stokely, C., & Hamilton, C. V. (1967). *Black power: The politics of liberation in America*. New York, NY: Vintage Books.

The Black Manifesto. (2010). The price of race inequality. Retrieved from http://www.oneeastmidlands.org.uk/sites/default/files/library/black_manifesto_race_inequality.pdf

The Guardian. (2017, September 3). Four black men die. Did police actions play a part? Retrieved from https://www.theguardian.com/uk-news/2017/sep/03/four-black-men-die-police-restraint-no-officers-suspended-bryant-cumberbatch-charles-da-costa

Thornicroft, G. (2006). *Ethinicity of patients in high security psychiatric hospitals in England. Delivering Race Equality in Mental Health Care*. London: Institute of Psychiatry, Kings College London.

Tortelli, A., Errazuriz, A., Croudace, T., Morgan, C., Murray, R. M., Jones, P. B., … & Kirkbride, J. B. (2015). Schizophrenia and other psychotic disorders in

Caribbean-born migrants and their descendants in England: Systematic review and meta-analysis of incidence rates, 1950–2013. *Social Psychiatry and Psychiatric Epidemiology*, *50*(7), 1039–1055. Retrieved from http://doi.org/10.1007/s00127-015-1021-6

Walker, S. (2017). Relationship based teaching with (social work) students affected by globalism and the politics of location. *Educational Alternatives*, *15*, 48–55. Retrieved from https://www.scientific-publications.net/en/article/1001561/

Walker, S. (2020). Racism in Academia: (How to) Stay Black, Sane and Proud as the Doctoral Supervisory Relationship Implodes. In R. Majors, K. Carberry, T. Ransaw (Eds.), *The International Handbook of Black Community Mental Health* (pp. 89–107). Bingley: Emerald Publishing.

Xanthos, C. (2008). Racializing mental illness: Understanding African-Caribbean Schizophrenia in the UK. *Critical Social Work, Archive Volumes*, *9*(1). Retrieved from http://www1.uwindsor.ca/criticalsocialwork/racializing-mental-illness-understanding-african-caribbean-schizophrenia-in-the-ukIndex