Chapter 17

Forty Years in the Wilderness: A Review of Systemic Barriers to Reducing the Over-Representation of Black Men in the UK Psychiatric System

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I am a Black British woman who was born in Manchester in the North West of England in the 1970s. My parents are both Jamaican and came to this country in the late 1960s. I grew up in inner-city Manchester in a largely African-Caribbean and South Asian community. Within my experiences of this community, white people were considered as ‘racist’ and it was ‘common knowledge’ that as a Black child I would have to work twice as hard to achieve educational or economic ‘success’ and to avoid being arrested or blamed for something. Not because of any inherent biological deficit we possessed, but simply because of ‘racism’. Within the community we were encouraged not to trust ‘white people’. I have friends from these communities who have been arrested, beaten up by police, faced discrimination at work or who have been sectioned onto psychiatric wards, mostly black men. In terms of gender roles, I have grown up seeing black women being ‘strong’ out of necessity (often the breadwinner of the family) and black men who seem to be defeated. As a child in school, I and my female black friend, ‘knew’ that we would have a better chance at ‘success’ than our male counterparts. This was particularly relevant in the classroom, where we often witnessed black boys getting into trouble and being placed in lower educational streams. Little was expected of them.

The above statement is taken from the personal reflection I included in qualitative research almost 16 years ago. This was written in the spirit of an Afrocentric
researcher presenting sufficient information about myself to enable readers to assess how and to what extent my presence influenced the choice, conduct and outcome of the research. From that research emerged a framework for conceptualising the development of a persecutory framework for black men living in the UK, in the context of social inequality, loss, institutional racism and additional powerlessness, international over-representation and death in the psychiatric system. This is partly represented in Fig. 1.

This chapter briefly summarizes research over the past four decades (and prior) associated with black men and mental health in the UK. The chapter also examines some responses to the research. This is because we unfortunately remain in a situation where black men in Britain are 17 times more likely than white counterparts to be diagnosed with a psychotic illness. This is an appalling situation but the sense of shame that this should invoke in the UK seems to dissipate decade after decade.

Research into the mental health needs of black men has been conducted repeatedly in the UK, with each new generation hopeful for change. By briefly exploring some policies that have emerged to address this inequality, this chapter highlights the barriers to change. The argument being that we have conducted the research and we undoubtedly have the answers, but yet progress is at best slow, if at all evident. We need to be honest about why this is.

**What We Know**

Research into the mental health needs of black men in the UK highlights issues that are well known, such as the use of coercive pathways to care, the overuse of medication, under-representation in access to psychological therapy, the mistrust of psychiatric services amongst black communities in the UK and the subsequent impact on engagement with services.

**Recurrent and Repeated Themes**

My doctoral research submitted in 2002 (Coleman, 2002) used semi-structured interviews to explore the content and form of delusions experienced by African and African-Caribbean men with psychiatric histories. Additionally, staff members who worked with these groups were interviewed. I reviewed the research available at the time and concluded that it was unfortunately well established that rates of psychotic illness amongst the African-Caribbean population in Britain were elevated compared to the indigenous white British population. I specified that this was first noted by Hemsi (1967) and pointed to a number of subsequent studies indicating the same over-representation (see Bagley, 1971; Bhugra et al., 1997, cited in Gilvary et al., 1999; Harrison et al., 1989; Leff, Fischer, & Bertelsen, 1976; McGovern & Cope, 1987; Os Van, Castle, Takei, Der, & Murray, 1996; Wesseley, Castle, Der, & Murray, 1991).

I also referred to Professor Robin Murray and researchers at the Institute of Psychiatry in London, who concluded that black people were not genetically more prone to schizophrenia. Furthermore, it was found that although 75% of white
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patients with schizophrenia had some biological reason for their illness in the black population this was only 25% (BBC News Online, 2000). Prior to this, it was noted that African-Caribbean patients were less likely to be offered psychotherapy and more likely to receive electroconvulsive therapy and higher doses of medication (Littlewood & Cross, 1980). Littlewood and Lipsedge (1988) also reported high admission rates under the Mental Health Act and over-representation of black patients in secure units and special hospitals (Littlewood & Lipsedge, 1981; McGovern & Cope, 1987).

In a classic summary, Littlewood and Lipsedge (1988, p. 950) cite explanations for the excess rate of schizophrenia which included: the experience of migration and ‘status striving in a climate of limited opportunity’ (Bagley, 1971; Giggs, 1986) and a culturally determined response to adversity (Bebbington, Hurry, & Tennant, 1981); patterns of service utilisation (Cochrane, 1977), that is, depressed African-Caribbean populations were found to be less likely to seek psychiatric treatment, seldom offered admission and if they were admitted they were more likely to be diagnosed as schizophrenic.

At the time, I observed that it had been repeatedly stated in the literature that in the Caribbean, rates for psychotic illness are not similarly elevated. For example, Hickling and Rogers-Johnson (1995) found a restrictive CATEGO schizophrenia diagnosis first contact incidence rates for the black population in Jamaica of 1.16 per 10,000. This is slightly lower than the rate of 1.4 per 10,000 for the general white population in Nottingham, UK (see Harrison, Owens, Holton, Neilson, & Boot, 1988) and falls within the indicated range of the WHO International Schizophrenia Study (Sartorious et al., 1986). Additionally, it did not compare with Harrison’s findings of 13.5 and 36.4 per 10,000 of schizophrenia for first and second-generation African-Caribbeans in Nottingham (predominantly Jamaican origin) respectively. See also Hickling (1991) and Bhugra et al. (1996).

These findings were taken as evidence that the risk is greatest in African-Caribbeans born in Britain (second generation) and indicated that there are adverse environmental factors in operation (see Gilvarry et al., 1999) Wesseley et al. (1991) cite frequent exposure to social adversity. Cochrane and Bal (1989) suggested that this may affect African-Caribbeans born in the UK as much as, or more than their parents.

At the beginning of the twenty-first century, McKenzie, Samele, Van Horn, Tattan, and Van Os (2001) carried out a secondary analysis of 708 patients with research diagnostic criteria-defined psychosis from a two-year randomised control trial of case management. They found that people of Caribbean origin living in the UK were more likely to be diagnosed as suffering from schizophrenia than British whites (AC, 50%; BW 31%). They were also less likely to have A-levels or a degree (AC, 8%; BW, 24%).

These studies were the substance of my review at time. With regards to results of the interviews I conducted, three themes emerged. These are summarised in the next section.

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1This is a computer programme used to classify patients into diagnostic categories.
Being or Becoming Ill

In terms of this particular sample, analysis of data suggested that when a person becomes ill, they often experience a sense of distress, due to certain life events or due to the specific symptoms they are experiencing. Their ‘self-trust’ may be affected and they may begin to question their own sense of judgement. Alternatively, they may hold firmly to the reality of the experience. However, whether they believe the experience or not, it may be experienced as overwhelming. Hence, the person becoming ill may then seek others to help.

‘Others’, such as family members, may themselves feel distressed by what other person becoming ill is going through. They may then feel a need to call additional ‘others’ such as the police or the psychiatric system who can ‘help’. Generally, ‘others’ may feel torn between wanting to accept what the person becoming ill is experiencing, feeling the need to control the person in some way and fears about potential collusion. However, the first response according to the interviews conducted is more likely to lead to the person [becoming ill] engaging with others. Alternatively, if the person becoming ill is faced with attempts to control them, they may understandably attempt to hide their symptoms or ‘play the good patient’ once in the mental health system. Other ways of coping, included attempting to regain control outside of psychiatry. This may or may not include taking part in religious activity.

The Persecutory System

The second emergent concept concerned ‘persecutory systems’. The dominant persecutory system is described as nameless and appears to be a vehicle of control, oppression, racism, discrimination and social inequality. This system has a number of facets within it. An exception to this system was a spiritual persecutory system based on a Christian framework.

A merge between real persecutory experiences and ‘delusional’ persecutory experiences at the hands of the social persecutory system was indicated. There were also frequent references to what appeared to be real experiences of persecution, with the police being mentioned frequently in addition to racist name calling from peers or ‘mates’. The reason for persecution appeared to be related to the recipient’s racial identity.

In terms of racial identity, the impact of rejection in the context of a racist society is perhaps evident in this quote from a staff member, Andrew, a white British staff nurse in the NHS:

We had this one guy who erm, who thought … that he’d been poisoned by his white foster carers. In order to turn him from a black child, into a white child. He was quite pale. Pale skin. I think his

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2Pseudonym.
mother was white, his father was African I think, erm and he believed that his complexion, his skin colour had lightened as he'd grown up, that he was changing into a white person, but it, a very kind of sad delusional explanation for his kind of experiences as a child really, you know, living in foster care, he was kind of rejected by his mother. Kind of issues, that’s one example, but I’m sure there are others.

There appeared to be a strong sense of helplessness and frustration in the face of persecution. However, arguably adaptive responses to persecution included ignoring the persecutors and not fighting back. Occasionally people would fight back, but this tended to be aimed at perceived individual persecutors, rather than persecutory systems.

The persecutory system also included the psychiatric system, housing authorities which were viewed as discriminatory and places of employment. These systems were often linked with institutional racism. With regards to housing, the Grenfell Tower tragedy London is perhaps testament to the impact of inadequate funding decisions and arguably to discrimination (see Hanley, 2017).

Steven an in-patient of African-Caribbean origin stated:

[…] it’s like when you go for a job and if they don’t, don’t like you, just like, I really want them to say ‘oh we don’t like you, so leave the premises’ I’d like them to say that … if you go to the workplace and you tell them, ‘oh yeah’, I’m an advanced student er I’m applying for this job it’s like because of your appearance or something, they won’t give you the job.

With regards to housing and a sense of discrimination, Steven also stated:

[…] even housing and all that, they don’t want to give you a place. I went to a housing place one day and said er ‘can I have a flat or somewhere?’ … I asked for a two storey flat or, so they offered me some flat, a high rise, you know what I mean, and I didn’t want it, I didn’t want it. But it was the only place they wanted to offer me … I took the place, I just, I couldn’t live in them conditions.

Concerning the police, Steven added:

[…] he’s got nothing to say, a policeman comes up to you … he just wants to lock you up, so he wants to lock you up ‘cause your Black … in their statement, it said, erm, ‘he believed to be a half-caste dood’. Know what I mean so, my dad, my dad’s got vex now… said erm, erm, ‘How could they say that, how could they say that, when you’re black?
Sam, an out-patient of African-Caribbean origin, suggested that one reason for the persecution was a fear of different cultures. He stated, ‘Yeah, I had a lot of experiences like that at school, when you get called names and I told my pa and he said, ‘don’t worry son, it’s the same thing happen to us when we just come over into this country’. Used to say we had tails and we were monkeys that we stunk, ‘cause we had tails hidden under our coats. It’s happening now with the Asians and the rioting and Oldham and being another colour, not only in Britain, but all over the world …. Not only I experienced it, my foreparents experienced it and … upto this day, we’re experiencing it …’.

Sam also referred to persecution being part of a conspiracy to wipe out black people. This was something he dwelt upon particularly when he first began to experience severe mental health difficulties. His distress was compounded by the fact that such practices might be quite overt, but still accepted at the time. He stated:

Slavery, wondering about slavery, and the conspiracy to erm, to erm, when the holocaust, the holocaust against the Jews and as a young person, you used to think about them things a lot, what if they do wipe out the black race, like they wiped out the Jews, all them things happening, as a youth, it’s on the news and it’s not hidden, it’s there in front of you. I used to think on it a lot, and done me head in. I couldn’t study or work or anything. I was less motivated to do anything, than white people are.

Sam later continued:

I think that’s part of what made me ill and all that, ‘cause I used to think hard on it, I wouldn’t go out and … fight against people, but it was spinning in my mind, after I’d been called names, what, how should I take, I didn’t know how to take it (lowers voice) you know being black … I used to sit down and write, ‘cause I’m black, I can’t get this opportunity’, ‘cause I’m black I can’t get that opportunity’.

Mental health staff made the following statements when referring to the African-Caribbean men they have worked with:

[…] persecutory ideas of abuse by a racist system, a system designed to keep them erm down and locked and incarcerated … it’s a nameless system, but geared with racism, a system designed from a thousand years to keep Black people in their place, you know I know it sounds funny, it’s a system, but it’s nameless and an unidentifiable system of facets which are keeping some people with them ideas down …. Yeah, a system designed which can belittle you and erm reinforced by media, family…school-teachers, nurseries, doctors, psychiatrists. System designed to erm
reinforce your, your (low position) in life. (Brian³; a Black British social worker of African Caribbean origin)

[…] most African-Caribbean men that I’ve worked with that suffer paranoia delusions, tend to look at it from, a persecution point of view from the ‘system’ er system including health authority, the doctors and the nurses er social services and particularly the police … usually it tends to be like the powers that be within the system here in Britain. (Carl⁴; a Black African support worker)

The sense of being silenced and the powerlessness and sense of hopelessness associated with this situation is perhaps highlighted in the quote below, from Sam⁵:

When I was in mental hospital and when I was in prison. I actually got beaten up…some of the screws⁶… I was naked and a pile of them come in the cell and beat me up and put me in a strip cell, chained and cuffed, on a cold floor. I’ve experienced some bad things but who listens anyway so … I don’t want to talk about it anyway so … I don’t want to start no trouble with no authority or anything, you know erm but they’ve been cases where a lot of Black men have died in custody and all that and I thought I could have been one of them … I don’t know if I’ve died and come back.

Loss Experiences

The interviews indicated that bereavements and loss of role/status/job at times in the context of migration contributed to the development of mental health problems.

With regards to the loss of a job, Carl (African support worker) stated:

I had a gentleman who I think it started off with a sense of persecution in terms of racism, ‘cause he had a very good erm role in (says name of a suburb) which is a very a white area, very middle-class area, and erm because of all this feeling of er racism towards him, he, it eventually led to the loss of job. And I think after a couple of months, he’d (sit down at home) and writing letters to the Queen and to the Prime Minister. He stayed up late nights, er days and nights I think and eventually he developed an illness.

³Pseudonym.
⁴Pseudonym.
⁵Pseudonym.
⁶A slang term used by prisoners to describe prison officers.
In terms of the impact of migration, Carl also stated:

They tend to have migrated as well, from one part of the world, where some like never ever had experienced racism, because there is no, there is no other person of a different colour to come and oppress them... I know some of the African cultures... not racism, but maybe tribalism... I think, a lot of people that have a break down here, tend to have grown up within a middle-class environment in their culture and have come here and have found it more or less impossible to fit into a similar kind of social class.

The interviews also highlighted the impact of the loss of cultural frameworks in addition to loss of parental figures. For example, John, an in-patient of mixed African and white British descent stated:

cause I, my first family was Irish family. That was my first family. I was fostered to, adopted... and I was with them for I think about ten years, then my foster mother died. I got moved on to a Jamaican family, so I’ve been in (coughs) two different cultures, so it’s been a bit of a mixed time for me to get used to one culture, to a next culture.

Previously held beliefs were also lost, for example, Sam stated:

I come in the winter, snow, first time I seen snow and aeroplanes and big cars and all them lights and it was nice though, it was a nice experience... coming to see my parents, 'cause I lived with my grandparents in Jamaica. They grew me up, then I come here, met my mother and father, and then found out that they was my mother and father, and that person who brought me up in Jamaica was me grand-parents.

An exception to the loss of a parental figure was the sad experience of Terence, an out-patient of African-Caribbean descent. He stated:

I had a baby that died... I can remember I can hear these like, hear him saying to me, 'we, we’ve never hurt anyone and look what they are doing to us' I feel as if the baby’s saying that, the baby said that to me when he died. He died at the age of three.

According to the interviews, losses unsurprisingly had an impact upon their self-esteem, affective state and subsequent behaviour.

Development of the Persecutory Framework

Based on the interviews and emerging themes, a framework was proposed for the development of a persecutory framework. This is partly represented below.
On review and based on experiences of working across adult and child mental health services, I have added experiences of powerlessness in the education system. Hence, this represents an adapted model (see Fig. 1).

![Proposed Development of Persecutory Frameworks for Black Men Experiencing Persecutory Delusions in the UK.](image)

Fig. 1. Proposed Development of Persecutory Frameworks for Black Men Experiencing Persecutory Delusions in the UK.

**Still in the Wilderness**

Hence, despite the title of this chapter making reference to 40 years in the wilderness, which concerns the plight of oppressed Israelites in the book of Exodus in the Bible, the documentation of over-representation of African-Caribbean men in the UK psychiatric system is at least 50 years old. Unfortunately, there has not been a significant change in these figures despite evidence-based statements such as ‘Being black in Britain is bad for your mental health’ (McKenzie, 2007).

Kirkbride et al. (2012) conducted a systematic review of incidence rates in England over a 60-year period (1950–2009) to determine the extent to which rates of schizophrenia and other psychoses varied along accepted (age and sex) and less-accepted epidemiological gradients (ethnicity, migration and place of birth and upbringing and time). The researchers found that rates of most disorders were elevated in several ethnic minority groups compared with the white (British) population. For example, for schizophrenia: black Caribbean (pooled RR: 5.6; 95%CI: 3.4–9.2; \( N = 5 \)), black African (pooled RR: 4.7; 95%CI:
3.3–6.8; \( N = 5 \)) and South Asian groups in England (pooled RR: 2.4; 95% CI: 1.3–4.5; \( N = 3 \)). They found no evidence to support an overall change in the incidence of psychotic disorder over time, though diagnostic shifts (away from schizophrenia) were reported.

With regards to the incidence of psychotic disorders and ethnicity, they identified 26 citations (Baudiš, Matesová, Škoda, Kabešová, & Skodová, 1977; Bhugra et al., 1997; Carpenter & Brockington, 1980; Castle, Wessely, Der, & Murray, 1991; Castle, Wessely, Van Os, & Murray, 1998; Coid et al., 2008; Dean, Downing, & Shelley, 1981; Dean, Walsh, Downing, & Shelley, 1981; Fearon et al., 2006; Giggs, 1973; Goater et al., 1999; Harrison et al., 1997, 1988; Hemsi, 1967; Hitch & Rack, 1980; Kirkbride et al., 2007, 2008; King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994; Leff et al., 1976; Littlewood & Lipsedge, 1978; Lloyd et al., 2005; McGovern & Cope, 1987; Morgan et al., 2006; Rwegellera, 1977; Van Os, Castle, Takei, Der, & Murray, 1996; Van Os, Takei, et al., 1996), which provided incidence data in relation to ethnicity or country of birth. Schizophrenia was included in 18 of these, with 10 primary citations providing 37 overall incidence estimates in minority ethnic groups. Some citations also provided rates in different ethnic groups stratified by age and generation status.

Kirkbride et al. (2012) note that rates of psychotic disorder were most particularly and consistently raised for people of ‘black ethnicities’ compared with the baseline population in each study (typically those of white or white British ethnicity). The authors performed a random effects meta-analysis on data from five studies which presented overall incidence rates of schizophrenia in different ethnic minority groups. This suggested rates of schizophrenia were elevated in black Caribbean (RR: 5.6; 95% CI: 3.4, 9.2; \( I^2 = 0.77 \)) and black African (RR: 4.7; 95% CI: 3.3, 6.8; \( I^2 = 0.47 \)) migrants and their descendants, compared with the baseline population. This pattern was also evident for the affective psychoses, including bipolar disorder and psychotic depression independently. For substance-induced psychoses, one study reported higher first admission rates of cannabis-induced psychoses in black Caribbean men. However, the authors highlight unpublished data from the ÆSOP study (see later) which indicated that 92.6% of people with a substance-induced psychosis were white British, with the rest of mixed ethnicities.

Notably, they identified five citations (Bhugra et al., 1997; Fearon et al., 2006; Harrison et al., 1997, 1988; McGovern & Cope, 1987) which presented rates of psychotic disorder in different ethnic groups by age. Three of these (Bhugra et al., 1997; Harrison et al., 1988; McGovern & Cope, 1987) distinguished between first- and second-generation black Caribbean migrants and found support for raised rates of psychotic disorder for both generations. Two citations (Fearon et al., 2006; Harrison et al., 1997) presented rates of psychotic disorder by ethnicity across several age groups; rates were elevated at all ages for black Caribbean and black African groups.

Furthermore, Morgan et al. (2017) found that there was evidence that black Caribbean patients experienced worse clinical, social, and service use outcomes, and black African patients experienced worse social and service use outcomes, compared with white British patients. Baseline social disadvantage contributed to
these discrepancies. This was part of the AESOP-10 Study, a follow-up at 10 years of a cohort of 458 (initially 532) patients with first episode psychotic disorder initially identified in south-east London and Nottingham.

In this study, in order to capture exposure to multiple disadvantage and isolation, the researchers constructed an index by counting the presence of the following: unemployment, living alone, living in rented housing and being single. Service use involved information on contacts with mental health services. This included adherence with treatment (clustered into regular, irregular and none, based on appointment attendance and how frequently medication was taken). Clinical outcomes defined remission as absence of psychotic symptoms for six months. These were categorised into three types: episodic (no episode lasting more than six months) and neither episodic not continuous (at least one episode of more than six months and at least one remission of more than six months). Symptom recovery was defined as sustained remission for two or more years.

It was concluded that:

[...] one of our most striking findings is the high levels of social disadvantage and isolation, at baseline and throughout the follow-up, among Black Caribbean and Black African patients. This suggests that addressing the social needs of those from these groups should be a priority for mental health services. (Morgan et al., 2017, p. 6)

Whilst we hold this research in high esteem, the findings are arguably not surprising and reflect what people have been saying for decades. The authors also conclude:

More broadly, our findings mirror wider inequities in health in many marginalised and disadvantaged groups. This perspective draws attention to the social structures and processes, including institutional racism .... (Morgan et al., 2017, p. 6)

This conclusion is again arguably consistent with previous findings. Hence, we have policies such as The Five Year Forward View for Mental Health published by the Independent Mental Health Taskforce (2016) which states:

Some groups are disproportionately represented in detentions to acute and secure in-patient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average. This suggests a failure to ensure equal access to earlier intervention and crisis care services (Mental Health Taskforce, 2016, p. 31).

People with acute mental health needs will be able to access appropriate care, as in-patients or through community teams. Their housing, social care and other needs will be assessed on admission and the right support made available on discharge. Use of the Mental Health Act will be monitored, with a focus on black and minority ethnic groups (Mental Health Taskforce, 2016, p. 32).
Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level (Mental Health Taskforce, 2016, p. 82).

There have been a number of policies and inquiries to address such inequalities over the decades, such as: Inside Outside – Improving Mental Health Service for black and Minority Ethnic Communities in England 2003; The Independent Inquiry into the Death of Rocky Bennett published by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority & Department of Health (2003). New Horizons: a shared vision for mental health (HM Government, 2009); the fact that we live in an inherently racist society arguably buffers against change. The simplest analogy I can draw is when a parent who has a complex and dramatic life, at times impacted by experiences of abuse, brings their child to Child and Adolescent Mental Health Services and asks clinicians to ‘fix’ the child. The thinking being that the child will be fixed despite returning to live in an emotionally unstable home environment.

It is important to clarify that in the above analogy, the child is not the individual black male patient, the ‘child’ is the over-representation of black men in the British psychiatric system. Hence, the unstable home is the racist society commissioned with implementing policies. As such, policies that do not take into account the fact that they are being implemented in a racist society and which are not comprehensively resourced, with long-term investment as a basic requirement, rather than short-term funding will not suffice because in essence they represent an attempt to ‘fix’. This is not a ‘quick fix’ situation, as the decades of research with repeated themes testify. Additionally, good policies that change or are replaced based on the political climate arguably, have no place in addressing this situation.

As the following quote states:

We have an excellent plan for improving mental health services for black and minority ethnic groups, but we need to go further. If we knew that one group in society were 10 times more likely to develop lung cancer, we would focus on them - perhaps with a targeted anti-smoking strategy. We would not just make lung cancer treatment services more equitable …. Prevention of mental illness in black communities is the sort of complex problem that should attract a high-level government inquiry that leads to action. I am used to hearing politicians say that doing nothing is not an option. This is an area where the phrase has real meaning. The high rates of mental illness in people of Caribbean and African origin are not going to go away. If anything, their legacy will blight a generation and the impact will be felt by us all. (McKenzie, 2007)
Analysis and Conclusions

When we think of the term institutional racism, we often think of organisations, rather than a racist society. However, I often make reference to raising children in a racist society and the need for a conscious awareness of this when I teach trainee Clinical Psychologists, always hopeful that they will inspire change in the profession. I am in essence guilty of the same naivety of a quick ‘fix’. If real change is to occur it has to be independent of the political party in power and it has to take into account the fact that we live in a racist society. If not the design and implementation of such policies will be deficient.

In the UK, there have been and remain respected advocates over the decades, Professor Suman Fernando (who famously rejected his OBE) and Dr Kwame McKenzie come to mind in particular. They have championed the cause. Both men, both psychiatrists and both visible minorities. However, according to Walker (2017) we live in a society where a third of designated Sure Start children’s centres have been lost since 2010 in England, with 1,240 fewer than when the coalition took office.

Walker further states:

The north-east and London witnessed the biggest falls, with more than 40% of centres lost. Two local authorities, Swindon and Solihull, revealed in a freedom of information request that they had no designated centres left. More than 230 centres have been lost in the past year alone.

In response the Walker notes:

A DfE spokesman said: ‘These figures are misleading as they fail to account for children’s centres which are still offering vital services, but have been merged with other centres in the area to increase efficiency’.

Having focussed this chapter on the mental health of black men in the UK, the reader may be confused by a sudden focus on the needs of children. The reason is this, in a society that wants to rationalise inadequate care and support of children and their families, how can there be an expectation that the needs of marginalised groups will take priority? Additionally, the work to address the over-representation of black men in psychiatric systems has to include work with black children in the UK for generational change. Unfortunately, such focussed work is often viewed as a threat to ‘mainstream’ society. That is because mainstream society also faces discrimination, often based on class and social status. Ideally the needs of both white families living in poverty and marginalised groups based on race will be met. Thus shattering the legacy of divide and conquer, that leads to varying levels of inequality in the UK. On a personal note, how could I know as a child that when there is an economic crisis, ‘we’ as black communities will be blamed and will be at the bottom of the pile. It is unfortunately because it is a reality I witnessed each day growing up in the UK.
Furthermore, more recently in the current era of austerity measures, I see this played out in politics and the media in the UK as part of a narrative the blames migration for the economic crisis.

In terms of the actual initiative to address the over-representation of black men in the psychiatric system, this has to be community psychology and psychiatry in practice. That is, comprehensive psychological formulations and initiatives that not only consider the impact of social reality, such as housing, employment and educational discrimination but also advocates work with agencies that represent social needs. This again is not a new concept. However, those agencies cannot be under-funded or under-resourced or short-term ‘pilots’. The work cannot be an ‘add-on’ but it has to be mainstreamed and provide an avenue for culturally appropriate psychological and social intervention. As stated, this work has to cut across child and adult services too, in order to affect change across the generations.

The initiatives need to be truly joined up, mainstreamed and positioned in such a way that they are not viewed as a threat. In 2012, in his 80th year, Suman Fernando stated, ‘You can’t mention equalities [within the Department of Health]. There is a sense that race is off the agenda’ (O’Hara, 2012). When I think back to the 1990s race was on the agenda, unfortunately in the form of short-term funding, but it was on the agenda. At that time, I was co-chair of the North-West ‘Race’ and Culture Special Interest Group of the British Psychological Society (BPS). It is perhaps significant that both the national and regional ‘Race’ and Culture SIGs no longer exists in the BPS. I also conducted research on making clinical psychology services more accessible to black communities in Manchester, North-West England (see, Coleman, Brown, Acton, Harris, & Saltmore, 1998). I was hopeful of change.

As stated, in the current climate of austerity in the UK, it certainly feels that race is no longer prioritised on the mental health care agenda. O’Hara (2012) notes: Despite being on several mental health advisory boards over the years, including Mental Health Act Commission, Fernando’s career is marked by his refusal to accept that a few political initiatives are evidence of real change. I am unfortunately inclined to agree.

References


