

Better  
Health  
Briefing

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**African and  
Caribbean men  
and mental  
health**

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## Key messages

- 1 The relationship between 'race', racism and mental health is complex and more research is needed to understand the links
- 2 Black males find themselves in situations that place them at greater risk of mental health problems, such as exclusion from schools, social deprivation, crime and drug cultures and racial victimisation
- 3 Black men are less able to identify that they have mental health problems, are unaware of sources of help, and fear that contact with services will lead to loss of status. Yet, mental health professionals find it difficult to talk about issues of 'race' and racism
- 4 Men from African and Caribbean backgrounds are over-represented in mental health services. They come to the attention of services via the police and the criminal justice system, and are more likely to receive the harsher end of services, such as seclusion, control and constraint
- 5 African and Caribbean men have negative perceptions of mental health services and therefore delay seeking help. This means that more coercive methods are used to engage them with mental health services
- 6 Mental health services are in a position to respond positively to the mental health needs of African and Caribbean men by building trust so as to address the damaging effects of racism on emotional well-being.

## Introduction

The mental health needs of African and Caribbean men is an area for public concern. A substantial body of research shows that these groups are disproportionately represented in mental health statistics. For example, the [Commission for Healthcare Audit and Inspection's \(2007\)](#) report on a one-day census of mental health inpatient wards in England paints a bleak picture for black and minority ethnic people, in particular those of African and Caribbean background. This disturbing situation persists despite the fact that the needs, issues and concerns of black and minority ethnic people with mental health problems have been pushed to the fore of the policy agenda (DH, 2003; DH, 2005). It has been acknowledged that achieving good mental health care for individuals from these communities is one of the biggest challenges for mental health services in England and Wales ([Commission for Healthcare Audit and Inspection, 2005](#)) because the disparities in rates of mental illness, treatment, care and outcomes remain. Explanations for this seemingly intractable situation are mixed and varied.

This paper explores the complexities involved when we link mental illness with issues of 'race', culture and ethnicity; reviews some of the evidence for African and Caribbean men; and makes suggestions for addressing these in mental health practice. African and Caribbean men have been singled out because these groups continue to experience the greatest disparities in mental health services. This paper focuses on settled communities from African and Caribbean backgrounds and does not discuss the needs of men from refugee and asylum seeker communities — although this is not to deny that men from these groups face even worse conditions in relation to their mental health needs. The paper also has a bias to the crisis end of services, because that is where the majority of African and Caribbean men with mental health support needs are concentrated.

## A complex relationship

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A number of difficulties arise when concepts such as mental illness, 'race' and racism are linked for analysis and understanding. First, we encounter debates about what is mental health and how best to treat it. The World Health Organization views mental health as: *'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'* (WHO, 2001). However, little is known about the extent to which African and Caribbean men share or subscribe to this understanding of mental health. More work is needed to explore their views and perspectives on mental (ill) health and how this may affect their willingness to seek help when it is needed.

Second, we also encounter debates about the meanings and significance of racism and its relationship with mental ill health and the most effective ways of reducing the inequalities experienced by black and minority ethnic communities in mental health services. [Karlsen \(2007\)](#) cogently illustrates the connections between racial discrimination and poor health, and concludes that people from black and minority ethnic groups experience poor treatment due to negative attitudes towards them.

There are also particular issues for men in relation to mental health. They often find themselves in conditions and situations that are considered as risk factors for mental illness. These are: exclusion from school (84 per cent of children excluded from schools are boys); social deprivation as a result of unemployment; prevalence of crime and drug cultures; and over-representation of men in prison populations ([White, 2006](#)). It has to be acknowledged that for African and Caribbean men, these experiences are underpinned or informed by their experiences of racism.

## Resources 1

### Antenna Outreach Service

[www.beh-mht.nhs.uk/services/directory\\_of\\_services/haringey/adults.shtml](http://www.beh-mht.nhs.uk/services/directory_of_services/haringey/adults.shtml)

Antenna Outreach Service is a culturally specific mental health service, which works with Black African/African-Caribbean people aged between sixteen and twenty-five years, who suffer the effects of mental illness.

Antenna offers individuals and their parents support, advice and practical help with regard to mental health.

### Better Must Come (Video)

[www.scmh.org.uk](http://www.scmh.org.uk)

*Better Must Come: Black men moving on* features seven black men overcoming stigma, discrimination and the myth that people with mental health problems cannot work. The video shows how big the barriers to work can be, and how they can be tackled successfully with the right support and advice. The men go to college, do voluntary work or go straight into employment. Many get support from community organisations, specialist mental health employment services and Jobcentre Plus advisers. The video shows sources of support, and how black men can get access to them. It can be ordered online at the website address above.

## 2 The context of greater risk

Britain is seen as a multi-ethnic and multicultural society where the population of minority ethnic groups is steadily increasing. The 2001 census showed that these groups comprise about 8 per cent of the population, and are concentrated in London and other inner-city areas. Black and minority ethnic communities occupy particular positions of disadvantage in the UK. Inequalities are reflected across all indices of economic and social well-being (White, 2002). They generally have higher rates of unemployment, live in poorer housing, report poorer health, and have lower levels of academic achievement, higher rates of exclusions from schools and over-representation in prison statistics (White, 2002). More specifically, African and Caribbean young men are more disproportionately affected by these inequalities. For example, recent evidence on school exclusions indicates that African-Caribbean boys are three times more likely to be excluded than their white counterparts (Joseph Rowntree Foundation, 2005). The situation is equally negative for those from 'mixed' backgrounds. These disparities continue to exist for these groups in situations in later life. For example, unemployment statistics show that African and Caribbean men and those from 'mixed' backgrounds are between 15 and 20 per cent more likely to be unemployed than their white counterparts (Berthoud, 1999).

## 3 Resistance to talking 'race'

As mentioned earlier, one enters a contested area of knowledge when concepts such as 'race' and mental illness are linked. Most authors propose that a key to understanding issues of 'race', culture and ethnicity is to be clear about how these are defined. I would argue differently. Following the lead of Cooper *et al.* (2005), 'race' and ethnicity should be viewed as social constructions, which therefore will have different individual and societal meanings depending on the context in which they are applied. An important issue to consider is the meanings that are attached to 'race' and its subcomponents of ethnicity, culture and racism. More importantly, it has to be acknowledged that these concepts carry what Knowles (1999, p. 125) terms '*the edifice of negative social meanings*'. One cannot therefore assume that all black people will assign similar meaning and value to being cast in the role of 'other' and, by implication, an inferior, so may not identify themselves as being part of an institutionally racist situation. 'Race' also constitutes only one dimension of black identities, albeit an important one for black people, but it overlaps with other social divisions such as age, class, gender and sexuality.

Another issue to consider is the impact of racial disadvantage and discrimination on individuals, their families and communities. Patel and Fatimilehin (1999) suggest that the impact of racism is psychological, social and material. The effect of this is likely to be detrimental to mental health, but it has to be borne in mind that for some it may be minimal, whereas for others it may be of great significance to their emotional well-being (Karlsen, 2007).

In relation to mental illness, men are in general less able to identify themselves as experiencing mental health problems, lack awareness of available sources of help and are therefore reluctant to seek help (Men's Health Forum, 2006). The reasons for not seeking help may be due to a fear of the possible consequences, such as loss of status, control, independence and autonomy (White, 2006). The range of problems is even greater for African and Caribbean men, based on their perceptions of mental health services and a belief that these services will discriminate against them (Keating and Robertson, 2004; Men's Health Forum, 2006). More importantly, a real and potent fear exists that engagement with mental health services will lead to their death (Keating and Robertson, 2004). I therefore argue that

prior to improving aspects of mental health service delivery, such as access to care, appropriate treatment, etc., we need a critical understanding of connections between culture, ethnicity, 'race', racism and mental illness.

It is also interesting to note that mental health professionals are not comfortable talking about issues of 'race' and racism (Keating *et al.*, 2002). Karlsen *et al.* (2005) suggest that an understanding of the relationship between these concepts may help us to understand the disparities for African and Caribbean men in mental health services. The impact of racism therefore has to be analysed in the context of histories of migration, histories of alienation, the subordination that resonates for these groups and the way in which these groups have been stigmatised and continue to be stigmatised in society today.

#### Over-representation and harsher services

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Evidence from the field of mental health shows that African and Caribbean men are over-represented in mental health services and are mostly found at the harsher end of services. The 2006 census of inpatient services in England and Wales (Commission for Healthcare Audit and Inspection, 2007, p. 35) in relation to black and minority ethnic communities found that for African and Caribbean people:

- The rates of admission to hospital were three times higher than average.
- Referral rates from general practitioners were lower than average and rates of referral from the criminal justice system were higher than average.
- There was greater involvement of police in referrals.
- Rates of detention under the Mental Health Act 1983 were between 19 and 38 per cent higher than average.
- There were higher rates of detention in medium and high secure wards.
- There were higher rates of control and restraint.

What is most dispiriting about this report is that the rates are increasing for those in the 'White/Black Mixed' groups. There are as yet no explanations for this, but it is clear that the issues for this group urgently need much closer scrutiny and analysis. The report concluded that although many explanations have been offered for these patterns, the evidence is still inconclusive. It urges statutory agencies, in partnership with others, to plan and commission services that will improve the pathways of care for black and minority ethnic groups.

There is also evidence that African-Caribbean people with mental health problems are more likely to receive medication as the primary form of treatment, are less likely to receive psychotherapy and are increasingly likely to attempt suicide (McKenzie *et al.*, 2001). The lack of referrals for

## Resources 2

### Black and Minority Ethnic Service User Network

[www.catchafiya.org/](http://www.catchafiya.org/)

Catch-A-Fiya is a survivor-controlled forum for mental health system survivors, funded by the Big Lottery Fund to facilitate positive change for survivors over three years. The primary purpose of the project is to establish and maintain contact with survivors from black and minority ethnic communities, and support them to learn, teach and grow.

### Department of Health (DH): Positive Steps Initiative

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_066059](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_066059)

The DH, as part of the Delivering Race Equality programme, has produced a guide (*Positive Steps: Supporting race equality in mental health care*) that provides hints and tips for practitioners to improve the quality of care for service users from black and minority ethnic communities.

psychotherapy has significant implications if we bear in mind that men are less likely to talk about their emotional problems. The increased risk of suicide is also an area of concern and needs further exploration.

It is clear from the above that individuals from African and Caribbean communities do not receive equal care. This situation seems unchanging, as is illustrated by a study that explored the views and experiences of African and Caribbean communities of mental health services in Birmingham ([Rabiee and Smith, 2007](#)). This study found that service users, on the whole, have negative perceptions of mainstream mental health services. The service user survey, as part of the black and minority ethnic 'Count Me In' census of 2005 ([Mental Health Act Commission, 2006](#)), found that black service users were most disadvantaged in inpatient services, they reported higher levels of dissatisfaction with their care and were more likely to have harsher treatments, such as control and restraint, meted out to them.

Some key thinkers in this area have sought biological explanations for these disparities, others have looked for more social explanations ([Sharpley et al., 2001](#); [Morgan et al., 2004](#); [McKenzie, 2006](#)), while yet others offer racism as a causal factor ([McKenzie, 2002](#); [Fernando, 2003](#)). However, none of these hypotheses has fully explained why the situation for black people in relation to mental health has persisted over the last thirty years. For example, the hypothesis that suggests that racism based on skin colour is a causal factor does not explain the mental health disparities for Irish communities in England ([Pilgrim, 2005](#)). Life stressors have also been suggested as a causal factor, but [Gilvarry et al. \(1999\)](#) found no differences in life stressors between white and black ethnic groups, but did find that black people will attribute adverse life events to racism. [Karlsen \(2007\)](#) also illustrated how adverse life events can have a damaging effect on the mental health of black people. The implications of this are that black people may therefore be disinclined to use services which they perceive as prejudiced against them.

## 5 Mental illness and perceptions of services

There are many competing perspectives on what constitutes mental illness. [Bracken and Thomas \(2005\)](#) argue that our knowledge of mental illness and distress is incomplete and new ways of thinking about mental illness are continually emerging. (For a more detailed analysis and critique of the debates on madness, see [Coppock and Hopton, 2000](#); [Fernando, 2003](#); [Bracken and Thomas, 2005](#).) [Coppock and Hopton \(2000\)](#) argue that there is ample evidence to show that mental illness is not merely a biological issue, but is also affected by social and political circumstances. Regardless of the perspective or approach taken to understand mental illness, it has to be acknowledged that when a person is assigned a label of mental illness, they take on an identity that is stigmatised and valued negatively ([Knowles, 1999](#); [Johnstone, 2001](#); [Fernando, 2006](#)). Mental illness can be deeply dehumanising and alienating. It is generally regarded with anxiety and fear, and leads to rejection and exclusion. A report by the [Social Exclusion Unit \(2004\)](#) found that people with mental health problems are among the most disadvantaged and socially excluded groups in society.

### Power of mental health institutions

Psychiatry is the only branch of medicine that has a legitimate role to forcibly treat, restrain and control individuals. These functions of providing care, control and accommodation are now delivered through a network of newly configured mental health services, such as community mental health teams and early intervention teams ([Rogers and Pilgrim, 2001](#)). Mental health professionals have the power to name and

rename emotional distress. [Pilgrim \(2005\)](#) argues that racial biases mean that these groups are disproportionately dealt with by specialist mental health services, and as these services are characterised by coercive practices, one could view this as structural disadvantage.

A factor that contributes to the disadvantages that African and Caribbean people experience in mental health services is the 'risk agenda' that has dominated mental health policy over the last number of years. For example, the current review of the 1983 Mental Health Act, with its focus on extending compulsory treatment to the community, can only serve to intensify the problems faced by black men.

### 'Blackness' and 'madness': the negative spiral

The stereotype of 'big, black and dangerous' was fixed in the popular perception by the case of Christopher Clunis, a black man with a diagnosis of schizophrenia who killed Jonathan Zito in 1992 on the underground in London. [Keating \*et al.\* \(2002\)](#) have demonstrated that stereotypical views of black people, racism, cultural ignorance, stigma and anxiety associated with mental illness often combine to undermine the way in which mental health services assess and respond to the needs of black and minority ethnic communities. It is clear that young black men end up with an extremely racialised profile of their mental health. Being seen as 'big, black, bad, dangerous and mad' can lead to conceptions that they are less deserving of treatment that would lead them to pathways of recovery. Therefore, the evidence shows that more punitive and restrictive forms of treatment are meted out to these groups.

The issue for black people is twofold. In life generally they have to continually be aware that in everything they do, they are being measured against how they fit 'the norm'. In mental health they have to cope with/manage (mis)conceptions about black people, particularly the popular views that have also become embedded in mental health practices.

What is clear from this is that for black people with mental health problems, there are at least four forces that underpin their experiences: (1) how black people are treated in society; (2) how people with mental health problems are treated in society; (3) the power of institutions to control and coerce people with mental health problems; and (4) the perceptions of black people of mental health services, and vice versa. Black people's experiences in society have an impact on their mental and emotional well-being. These experiences in turn influence how they experience and perceive mental health services. Their position (historical and contemporary) in society affects how they are treated in mental health services — and these various experiences interact to produce what [Trivedi \(2002\)](#) terms 'a spiral of oppression'. Black people do not trust mental health services, and those who work within them fear them, which means there is lack of engagement on both sides. The spiral can be presented as follows overleaf.

## Resources 3

### MIND Information and Fact Sheets

[www.mind.org.uk/Information/Factsheets/Diversity/The+African+Caribbean+Community+and+Mental+Health.htm](http://www.mind.org.uk/Information/Factsheets/Diversity/The+African+Caribbean+Community+and+Mental+Health.htm)

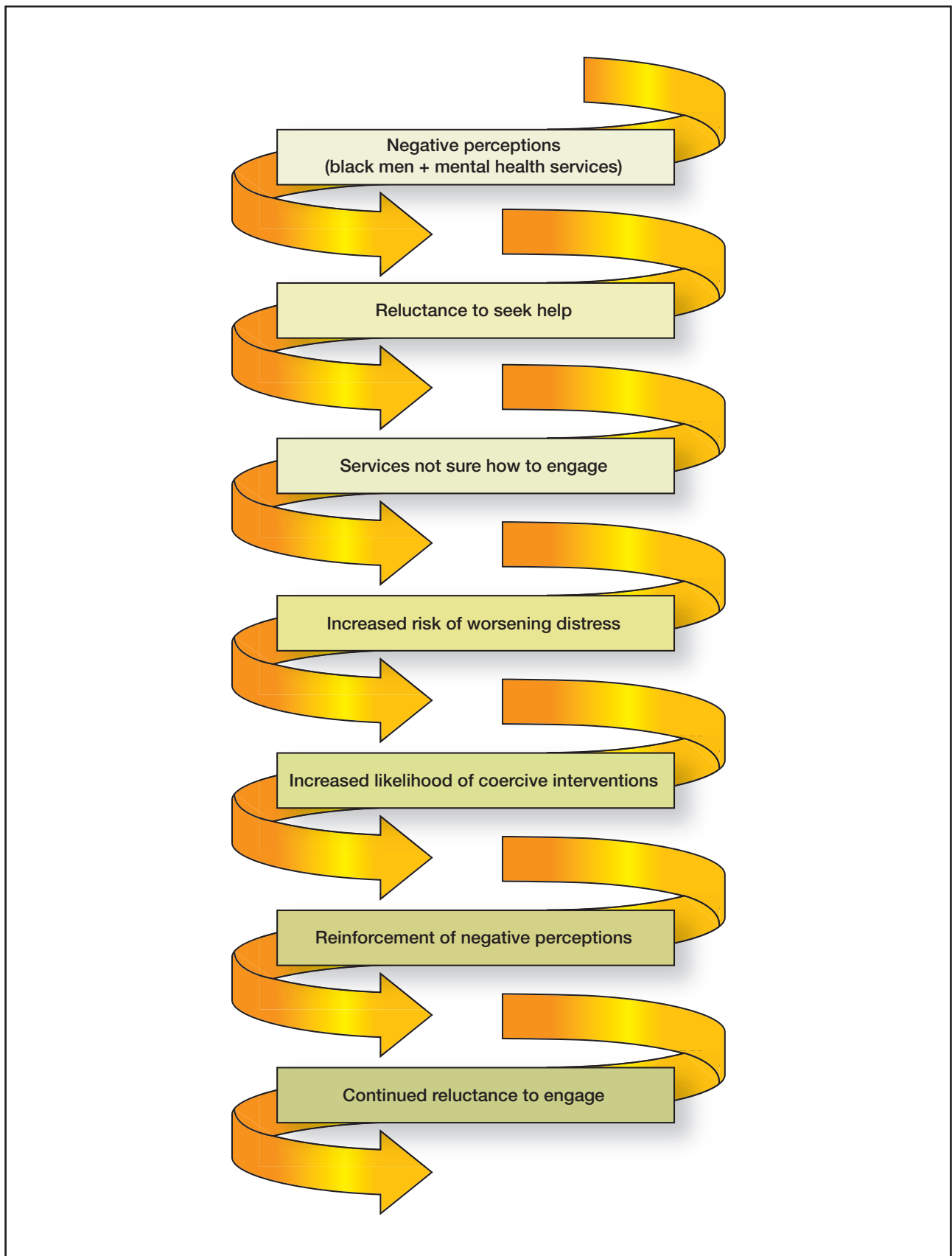
Mind works to create a better life for everyone with experience of mental distress by:

- ¥ advancing the views, needs and ambitions of people with mental health problems
- ¥ challenging discrimination and promoting inclusion
- ¥ influencing policy through campaigning and education
- ¥ inspiring the development of quality services which reflect expressed need and diversity
- ¥ achieving equal rights through campaigning and education.

### Mellow

[www.elcmht.nhs.uk](http://www.elcmht.nhs.uk)

The Mellow Campaign is a partnership programme. It aims to stimulate and develop creative and sustainable solutions to reduce the over-representation in mental health services of young African and Caribbean males, between the ages of eleven and thirty-four years, living in the boroughs of City/Hackney, Newham and Tower Hamlets.



The challenge for mental health professionals therefore is to break this spiral.

## Responding positively

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### A policy response

A tragic, but significant marker for black and minority ethnic communities was the death in 1998 of David (Rocky) Bennett while being restrained by nursing staff on a medium secure ward. After a long, drawn-out struggle by his family to achieve justice, an inquiry report concluded that mental health services are institutionally racist (Norfolk, Suffolk and Cambridgeshire SHA, 2003). The Government subsequently published an action plan for Delivering Race Equality (DRE) (DH, 2005). This plan has three building blocks: to develop more, and appropriate and responsive services; better quality information; and increased community engagement. As laudable as these intentions are, they contain a number of weaknesses. DRE focuses on organisational change, but fails to appreciate the heterogeneity in black and minority ethnic communities and the complex range of identities and practices they contain (Bhui *et al.*, 2004). DRE, for example, covers all black and minority ethnic groups, which means there is a danger that the challenges and issues for specific groups, such as African-Caribbean communities, will be overlooked. It also fails to appreciate that the inequalities that exist for black people in mental health cannot be separated from the general inequalities that black and minority ethnic communities experience in society. Moreover, the problem seems to have been framed in the context of culture; therefore the focus is on developing a culturally competent workforce. Fernando (2003) argues that a focus on culture can in itself be racist and it therefore has to be examined in this context. Cultural competence has been considered as the most appropriate response to meeting the needs of black communities, but this has unfortunately led to a narrow focus on aspects such as dietary requirements, religious and spiritual practices and appropriate environments. These factors are important, but often mean that the more serious issues of institutional processes and practices that discriminate against black and minority ethnic communities are overlooked, left intact and unchallenged.

The DRE programme does seem to offer opportunities to redress the situation for African and Caribbean communities through its extensive programme of community engagement. It is funding eighty community projects to assess the needs of black and minority ethnic communities and establishing community development worker posts in Mental Health Trusts (DH, 2005). However, these projects seem to focus narrowly on needs assessment — to which one could argue that the needs of these communities are well documented in research, and that what is needed instead is development of strategies for meeting these needs. The Department of Health (2007) has published a guide to support mental health professionals to improve the quality of care for black and minority ethnic groups, which may help fill the gap in meeting needs.

## Resources 4

### Men's Health Forum

[www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

The Men's Health Forum, founded in 1994, is an independent body that works with a wide range of individuals and organisations. Now well established with an active membership, the organisation works for the development of health services that meet men's needs and to enable men to change risk-taking behaviours. Its members, partners, staff and executive officers bring a wealth of experience in health care, media, business and grassroots activity. The Forum mentions resources specifically devoted to black and minority ethnic men and mental health, including a resource pack. This resource pack aims to provide an overview of issues in relation to black and minority ethnic men's and boys' mental well-being. It has been designed to assist health professionals to develop approaches that are sensitive to the specific concerns and needs of these communities.

## Practice responses and examples

### *'Talking "race", talking mental illness': practitioners need to make connections between a person's lived experience, their behaviour and their distress*

In the Breaking Circles of Fear research, my colleagues and I found that mental health professionals were fearful of talking about issues of 'race' and culture, often due to a fear of being cast as racist or fear of 'getting it wrong'. It is evident that by *not* talking about these issues, they inevitably 'get it wrong'. I suggest that a starting point is to engage in a dialogue about 'race' and mental illness. Engaging with and reflecting on inequality, discrimination and oppression that arise from social divisions in society is deeply challenging. It is an invitation to examine who we are: our experiences of advantage and disadvantage, power and powerlessness, inclusion and exclusion ([Williams and Keating, 2005](#)).

Mellow, a mental health promotion unit in East London, focuses specifically on the mental health needs of African and Caribbean men through creative means of talk shows, drama and art. They run drama sessions on 'race' and mental illness to enable mental health workers to engage with the issues and to talk more safely about their concerns and develop plans to improve their practice.

### *'Creating safe spaces of entry'*

The mental health pathways of African and Caribbean men have been described as problematic ([Keating et al., 2002](#); [Commission for Healthcare Audit and Inspection, 2007](#)). They are more likely to come into contact with services via police or the criminal justice system, or on the instigation of their family members. Given the fraught nature of the relationships between black men, the police and other institutions of social control, and the deep mistrust black men have of these, it is important that we find alternative ways of engaging these men with mental health services. More importantly, however, ways need to be found of helping them to deal more effectively with the stresses of racism and everyday life. I suggest that young men need safe points of 'entry' into talking about their emotional distress. There is evidence that outreach services can work, but we need outreach of a particular type.

Antenna, a community-based outreach service for young African and Caribbean men, provides such a service. They use a model of peer support and mentoring and have successfully engaged with services those who have been deemed 'hard to reach'. They have shown that services able to reach out to young men in a way that is non-stigmatising but affirming of who they are and their struggles in society, can go a long way to addressing the social exclusion these young men face. Services also need to be set up where men who are more likely to be at risk of mental health problems are found. Black men need to be encouraged to talk about their concerns, but will only do so in environments that are non-stigmatising and safe. Safe spaces can only be created when mental health services change their negative perceptions of African and Caribbean communities, when they work to establish positive relationships with these communities, and when they offer services that address the lived experiences of black people.

### *'People need care that helps them to find their way back to meaningful existence, meaningful relationships, meaningful connections, restored identity'*

When black people come into contact with mental health services, they are offered standard medicalised responses to their situation and needs. Service users often report that mental health workers view them only in terms of their diagnosis and tend to deal with 'the illness' in isolation from other aspects of their lives.

This narrow focus on biological factors means that other factors that may have contributed to their distress, or have an impact on their treatment, often go undetected, untreated and unresolved. This leads service users to

conclude that services are inhumane and treat them without respect and dignity. We need services that can provide responses that speak to people's life circumstances, including those of racism, inequality and discrimination. This means incorporating their experience and viewpoints in an assessment of their situation. It also involves sharing and making meaning of the everyday activities of life. Practitioners are required to document the concrete details of people's lives. A significant aspect of understanding lived experience is to identify sources of oppression and to tease out the overlaps between 'race', ethnicity, culture, age, class, gender, (dis)ability, religion and sexuality.

## Conclusion

Eradicating the disparities in mental health treatment and outcomes for black people requires changes in how these communities are viewed. Making services more humane at the interpersonal level is deeply important. Everyone values positive relationships: they are key to good emotional and social functioning. People who have been excluded or marginalised and have suffered emotional distress are in greater need of positive relationships. Mental health services should build positive working relationships with black men and engage with the ideals they have of themselves.

The over-representation of black men in mental health services, and their negative experiences, call for a multidisciplinary and multi-agency approach that should involve service providers, such as the criminal justice and educational systems, etc., outside the field of mental health. Schemes need to be developed to divert African and Caribbean men with mental health problems away from the criminal justice system. There should be greater focus on prevention and early intervention. There needs to be an active programme of mental health promotion aimed at black men. There is a small, but growing black service user movement and their efforts to improve mental health services should be supported. Efforts to improve the mental and emotional well-being of black men should be anchored in history, in broader societal conditions and contexts, and in their lived experiences, including experiences of racism. Such efforts should also take account of the ways in which black men have survived in the face of adversity.

## Resources 5

### **Mental Health Promotion**

[www.csip.org.uk/resources.html](http://www.csip.org.uk/resources.html)

The Care Services Improvement Partnership (CSIP) has developed a set of guidelines for mental health promotion with different black and minority ethnic communities in England. The guidelines set out a framework for delivering local interventions and addressing the needs of black and minority ethnic communities within mental health promotion strategies being implemented in response to Standard 1 of the National Service Framework for Mental Health.

### **National Black and Minority Ethnic Mental Health Network (BMEMHN)**

[www.bmementalhealth.org.uk/](http://www.bmementalhealth.org.uk/)

The BMEMHN is an infrastructure development organisation in the black and minority ethnic voluntary sector with a special focus on mental health. It aims to reduce inequality and promote good practice in mental health for racialised groups.

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We welcome feedback on this paper and on all aspects of our work. Please email [briefings@racefound.org.uk](mailto:briefings@racefound.org.uk)

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