Mental Health within the Black Community

Black people in the UK face a range of barriers to seeking and accessing mental health support, including mistrust of services, lack of representation and the design of services. Mental health services are often shaped by White colonial knowledge systems that fail to account for the lived experiences of Black communities.[1]

These barriers are rooted in structural racism and inequality. Structural racism shapes key determinants of mental health, including poverty, housing, employment, and access to resources, and impacts people across their life course.[2]

This resource provides an overview of key research findings related to mental health within Black communities, drawing on sources including national statistics and academic research. It explores disparities in mental health outcomes and the barriers Black people face to seeking and accessing support. It also highlights what needs to change, bringing together recommendations drawn from research to identify key actions required to address the mental health inequality faced by Black people in the UK.

Prevalence:

According to data from the Evidence for Equality National Survey, 25% of Black African people, 28% of Black Caribbean people and 42% of individuals from any other Black background met the criteria for anxiety, compared to 25% of White British people.[3] Similarly, 31% of Black African people, 46% of Black Caribbean people and 47% of individuals from any other Black background met the criteria for depression, compared to 45% of White British people.[3]

Analysis of 150,000 cases identified in the Clinical Practice Research Datalink included findings that serious mental illnesses, such as schizophrenia and other psychosis, have the highest prevalence in the Black ethnic group[4]. In particular, the prevalence of schizophrenia in the Black ethnic group was 0.98%, compared to a prevalence of 0.36% seen in the White ethnic group.

Ethnicity is not recorded on death certificates, so it can be difficult to understand ethnic disparities in suicide. However, although more males than females died by suicide across all ethnic groups in 2012-2019, there was a sex rate ratio of 9:1 (male to female) in individuals who identified as Black other.[5] Using the same dataset, it was concluded that Black African patients younger than 25 years old were more likely to die by suicide than any other ethnic group except White.[6]

Diagnosis:

Systemic biases within mental health services can shape how symptoms are treated, leading to misdiagnosis and unequal care. 87% of respondents to the Black British Voices Project believed that there is a problem with misdiagnosis within mental health systems.[7]

Black people are disproportionately diagnosed with severe mental illnesses such as schizophrenia. Research suggests this may be linked not only to higher levels of distress caused by racism, trauma, and inequality, but also to bias and misdiagnosis within mental health systems. Studies show that Black patients are more likely to have their experiences interpreted as symptoms of severe illness, while diagnostic tools and assessments are often based on White cultural norms and rarely take experiences of racial discrimination into account. This can mean people do not receive the most appropriate care and support.[8,9,10]

Risk factors:

In 2022/3 to 2024/5, 47% of Black children in the UK lived in poverty, compared to 22% of White children in the UK.[11] Children growing up in poverty are four times more likely to experience mental health difficulties.[12] Structural inequality, such as poverty, creates environments where stress and instability are more common, increasing risk factors for poor mental health.

There is strong evidence showing that Black people face significant housing inequalities. In 2021-2023, 18% of Black

people lived in a 'non-decent' home, compared to the UK average of 14%.[13] A home is categorised as non-decent if:

- It is without modern facilities
- It has ineffective heating
- It is in a state of disrepair
- It does not meet basic legal health and safety standards.

Black people are almost four times as likely to face statutory homelessness than White people. 10% of Black families gain access to social housing via the statutory homelessness system, compared to 24% of White families.[14] A person or family is statutorily homeless if they are legally defined as homeless, in priority need, and not 'intentionally' responsible for their homelessness.[15]

Social determinants of health, such as poverty and housing inequality, increase vulnerability to poor mental health and create additional barriers to accessing appropriate care.[16]

Limitations in data:

Despite clear evidence of unequal experiences of mental health care, limitations in how data is collected and prioritised prevent a full understanding of these disparities. This reflects and reinforces broader structural inequalities within the healthcare system.

For example, the Adult Psychiatric Morbidity Survey (APMS), conducted every seven years, is the most comprehensive survey of mental health in England. The latest survey (2023/4) involved 6,900 interviews and 880 clinical assessments. However, the APMS sampling method has long failed to accurately represent

the country's ethnic diversity, as small sample sizes for some ethnic groups prevent meaningful analysis. To improve this, a targeted oversampling of certain ethnic groups was agreed upon, to make it possible to draw conclusions about ethnic difference in mental health disorders. However, this was deemed to not be economically viable and was eventually phased out. In deciding that capturing certain experiences is not economically viable, it is argued that this decision is an illustration of structural racism within the healthcare system.[17]

Intergenerational trauma:

The term intergenerational trauma refers to the way in which trauma experienced by one generation can impact subsequent generations.

The hypothesis that a person's experiences might influence the cells and behaviour of their children and grandchildren has become more accepted. Small studies involving people exposed to traumatic events show subtle biological and health changes in their children.[18] However, concluding that trauma experienced in one generation will permanently affect future generations may create a misleading sense of hopelessness.[18]

In a study into intergenerational consequences of racism in the UK, it was found that at a systemic level, both parents and teenagers viewed racism as a pervasive 'inevitable' social norm.[19] Parents and teenagers discussed that their experiences of colourism had led them to internalise negative beliefs about themselves and their social value. When racism is experienced as an inevitable and constant feature of everyday life, it may

become internally absorbed, shaping how individuals understand themselves and their social value.

These internalised beliefs influence how both parents and children experience fear, sadness, and self-perception in relation to racism. These emotions are observed and shared within families, creating a dynamic with indirect effects of racism operating in both directions between generations.[19]

Over time, the accumulation of shared but unresolved trauma contributes to cultural patterns of silence and stoicism, where acknowledging mental health struggles becomes difficult despite their widespread presence.[7] 70% of research participants in the Black British Voices Project stated that they or members of their family had struggled with their mental health, but 87% reported that mental health was not discussed enough at home.

Disparities in access to, and experiences of, treatment for mental health conditions

Sources of support:

Black people are less likely to access support for their mental health through their General Practitioner and are more likely to access this support through crisis care.[20] They are also 40% more likely to access mental health support via the criminal justice system than White people.[20] Barriers to early intervention mean that support is often only accessed once needs have escalated.

Disparities in access and treatment:

Black people are more likely to receive medication or be detained than offered psychological therapy for their mental health, despite being at an increased risk for common mental health conditions (comprising of different types of depression and anxiety disorders).[21]

Black people are more reliant on specialist services than White British people[22], are overrepresented in crisis care and inpatient settings, and are more likely to be detained repeatedly.[23]

Entering the system at crisis point increases the likelihood of receiving more restrictive and coercive interventions. For example, Black people are more likely to be detained under the Mental Health Act. Statistics from the NHS show that 242 per 100,000 Black people were detained under UK Mental Health legislation, in comparison to 68 per 100,000 White people.[8]

Experiences of compulsory treatment and unequal care contribute to feelings of injustice, shaping how Black individuals understand and anticipate their interactions with mental health services. 81% of participants in the Black British Voices Project (2023)[7] considered mental health provision for Black people in Britain to be inadequate, and 87% expected to receive a substandard level of healthcare because of their race.

Inadequate or inappropriate treatment can allow conditions to escalate, increasing the likelihood of crisis-level outcomes, including suicide.

Case study: Maternal mental health

Mistrust of mental health services and known disparities can delay help-seeking and worsen mental health outcomes for those requiring maternity care.

Black mothers are twice as likely to be admitted to hospital with perinatal mental illnesses.[24] However, 20% of Black mothers with depression or a low mood reported that they did not seek professional help during the perinatal period.[25]

Black women often report that their pain was not believed or acted upon.[26] During labour, pain relief options were explained to 74% of Black women, but 23% did not get the pain relief they requested, and many reported being ignored when communicating that they were in pain.[27]

Biases such as healthcare professionals believing Black women to have higher pain thresholds can have a tangible impact on care and outcomes such as mortality.[28] Black women in the UK have

an almost three-fold higher risk of dying in pregnancy in comparison to White women.[29]

The psychological impact of awareness of adverse outcomes, including higher mortality rates, led some Black women to feel they were being treated as, or would become, a statistic.[25]

Barriers to seeking and accessing mental health support

Black people face a range of barriers to seeking and accessing mental health support, including mistrust of services, lack of representation and the design of services. These barriers are rooted in structural racism and inequality.

Mistrust of mental health services:

Mistrust is a significant barrier preventing Black people from seeking support and shapes experiences when accessing care. It often stems from historical and ongoing discrimination by services that are linked to oppressive structures.[8,30] For example, the deaths of Black men in mental health facilities continues to reinforce this mistrust in mental health services and can leave Black people "carrying more trauma than when they entered".[8]

Healthcare professionals must do more to understand the roots of mistrust and acknowledge how mental illness has been, and remains, deeply racialised.[31] For example, one of the most infamous cases of medical racism in U.S. history is The Tuskegee Study, which began in 1932 and lasted 40 years. Hundreds of low income Black men were enticed to participate in the study, the purpose of which was to observe the natural progression of untreated syphilis. No informed consent was gathered, and no treatment was offered to the participants, even when it was available.[32] As such, The Tuskegee Study has been called "the most enduring wound in American health science".[33]

In the UK, political policies can create and sustain systemic inequalities in mental health. For example, people of Black

Caribbean backgrounds in the UK experienced worse mental health following media coverage of the 2017 Windrush scandal[33]; a culmination of 30 years of racist immigration legislation.

The 'Windrush' generation are those who arrived in the UK between 1948 and 1971 from Commonwealth countries, which automatically granted them the right to live and work in Britain. The Windrush scandal surfaced in 2017 after it was exposed that thousands of people from the Windrush generation and their descendants were unable to demonstrate their right to live and work in the UK.[34]

Lack of representation within services:

A lack of representation within mental health services can be a barrier to both seeking and accessing care.[30] In 2023-4, Black people made up 5% of all staff working in Adult Community Mental Health services. This included 4% of psychologists and 3% of staff working in Adult Inpatient Mental Health.[36]

Representation also includes which experiences are recognised and prioritised within mental health services. When structural inequalities are not acknowledged, and mental health is viewed as a consequence of individual or cultural factors, it reinforces feelings of exclusion for Black people.[37,38]

Design of services:

Current mental health services in the UK are shaped by "predominantly White colonial knowledge systems"[1], which often fail to acknowledge the lived experiences of Black communities, including racism, migration and trauma.[1] This is reflected in

everyday experiences of care within mental health systems, such as a lack of recognition of lived experience and individuals feeling unheard.[1]

Power imbalances between professionals and service users can reinforce the unsuitability of services and be a further barrier to receiving person-centred care.[39] 63% of respondents to a survey conducted by Centre for Mental Health disagreed that current services provide suitable support to the Black community.[30]

Structural and systemic barriers:

Underlying these barriers are broader systemic factors that influence how people access mental health support. Structural racism operates across social, economic and political systems and maintains racial inequalities. It shapes the conditions in which people live, including poverty, housing, access to employment and access to nature.[2] Institutional racism within mental health services reflects and reproduces these wider inequalities.[8]

Because of this, the ways in which racism affects mental health are often not recognised or acknowledged. Its impact on health is sometimes invisible to those outside Black communities.[7] The Black British Voices project also found that 98% of survey respondents felt that the treatment of Black people by mental health services is problematic, reflecting how embedded these inequalities are.

What needs to change

Addressing the barriers described above requires moving beyond individual-focused approaches towards change that recognises the impact and influence of societal and institutional factors on mental health.

Research evidence highlights key areas in which change is needed:

Increase trust in services:

- Embed anti-racist and trauma-informed practice within all services, ensuring explicit acknowledgement of the impact of racism on mental health, alongside awareness of intersectional inequality and inequity[40]
- Demonstrate visible action to address institutional racism. Relying solely on policy change is unlikely to tackle "'the deeply embedded legacies of systemic racism"'[7]
- Build trust through sustained, empowering and effective partnership with community organisations, recognising the role they play in bridging gaps between services and communities[1,2]

Increase representation in services:

- Ensure that people with lived experience of mental ill-health, distress, and trauma are meaningfully included in the design and delivery of mental health services[1]
- Workforce training should be shaped by the expertise of those with lived experience[2]

Improve service design:

- Examine how Whiteness influences current mental health services and redesign services to deliver person-centred, culturally appropriate care that reflects lived experience[8]
- Address power imbalances by promoting shared decision-making and more equitable relationships between professionals and service users[39]
- Create models of community-led care that learn, evolve and offer a variety of culturally suitable options[2]
- Ensure that co-production is meaningful, authentic and not tokenistic. Co-production should, where possible, lead to the implementation of community-led recommendations[1], creating new and necessary changes within the mental health system that ensure an equitable future[40]

Address structural and systemic barriers:

- Data collection approaches must be strengthened to represent the ethnic diversity of the country, and investment should be made into methodologies that enable accurate analysis of inequities faced by minority ethnic communities[17]
- Increase collaboration and action between policymakers and services across sectors to address the conditions that shape mental health, such as poverty, insecure housing, and access to the community[2]
- Address discrimination within employment and increase representation within schools and the media[1]

- Commit to long-term structural change, recognising that systemic racism and inequality within mental health systems cannot be addressed through policy reforms alone[7]

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