



*Discussing race, racism and mental health:
Two mental health inquiries reconsidered.*

Ian Cummins: i.d.cummins@salford.ac.uk

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Abstract

The failings of “*community care*” in the late 1980s and early 1990s led to a number of Inquiries. This paper will examine one of these key issues that is rarely if ever at the forefront of the inquiry process – the experiences of young black men of African- Caribbean origin within mental health services and the Criminal Justice System (CJS). It sets out to do this by exploring the way, in which, two inquiries both from the early 1990s approached the issues of race, racism and psychiatry. The two Inquiries are the *Ritchie Inquiry (1994) into the Care and Treatment of Christopher Clunis* and *Report of the Committee of Inquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients* (Prins, 1994). The *Ritchie Inquiry* was established following the murder of Jonathan Zito by Christopher Clunis. *The Prins Inquiry* examined the circumstances of the death of Orville Blackwood at Broadmoor Special Hospital. These two Inquiries are used as contrasting case studies as a means of examining the approaches to the questions of race and racism. However, the attitudes and approaches that the Inquiries took to the issue of race are startlingly different. The *Prins Inquiry* takes a very clear position that racism was a feature of service provision whilst the *Ritchie Inquiry* is much more equivocal. These issues remain relevant for current practice across mental health and CJS systems where young black men are still over-represented. The deaths of black men in mental health and CJS systems continue to scar these institutions and family continue to struggle for answers and justice.

Keywords: Race, racism mental health inquiries

Introduction

The Inquiry Culture

The policy of "*deinstitutionalisation*" *i.e.* the closure of large psychiatric hospitals or asylums and their replacement with community-based mental health services has been followed across most industrialised nations. The term "*community care*" came to be used as a short-hand for this range of policy developments. In England and Wales, from the mid-1980s onwards this policy was increasingly controversial. In particular, it was seen as leading to a rise in urban homelessness (Cummins, 2011a). The media focused on a number of high profile cases of violent criminal offences committed by individuals with previous contact with mental health services (Cummins, 2011b). The failings of "*community care*" in the late 1980s and early 1990s led to a number of Inquiries exploring what had gone wrong in individual cases. The media reporting had all the features of a "*moral panic*" (Cohen, 2011) including calls for reform of mental health legislation.

One feature of the Government response was to establish a series of Inquiries into such cases. Brown (2004) suggests that an Inquiry serves to provide an "*authoritative account*" of an event or series of events. In addition, they should provide a means to examine the failings of the institutions or individuals involved. As well as providing an account for families – an account that might be available in a trial – then the Inquiry

seeks to make recommendations that will prevent such events occurring in the future. The Inquiry culture is an increasing feature of the revised structures of public services (Pollitt, 2003). In Beck's (1992) *risikogesellschaft*, the Inquiry can be seen as to give assurance that risks are being managed or will be in the future. Governments have been criticised for using the establishment of an Inquiry as means of delaying dealing with potentially political toxic issues.

Inquiries and Serious Case Reviews (SCRs) have become a feature of the landscape of health and social care services. It is clearly vitally important that all professionals and agencies seek to learn the lessons from serious or critical incidents. However, there are potential drawbacks to the development of an Inquiry culture. These include the fact that such investigations become a scapegoating exercise rather than a genuine attempt to address organisational, cultural or professional failings. Jones (2004) in his discussion of the Baby P case shows, in a very high profile case, the ways that the real questions about professional practice can become marginalised. As Manthorpe and Stanley (2001) show staff often are reliant on the media reporting of an Inquiry report, rarely having the time to access or consider the full document. In addition, there is a danger of a form of "*Inquiry fatigue*" developing whereby staff and professionals feel that "*all Inquiries say the same thing*" so important messages are missed.

As outlined below, one of the responses to the crisis in community care in the 1990s was the establishment of a series of Inquiries. Two mental health inquiries from the *Ritchie Inquiry (1994) into the Care and Treatment of Christopher Clunis* and the *Report of the Committee of Inquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients* (Prins, 1994) are used here as case studies for a

wider analysis. These Inquiries were chosen because of their historical overlap. In addition, they provide a basis for an examination of the experiences of young black men in both community and inpatient settings. The Ritchie Inquiry (1994) was the most high profile inquiry from this period receiving extensive media coverage, particularly in the tabloid press. The Prins Inquiry is not as well known and received limited media coverage. In this context, the two inquiries are used to explore aspects of mental health services. The focus is the ways, in which, the Inquiries examine the issues of race. There are important differences that need to be borne in mind. For example, Prins was examining an institutional culture while the Ritchie Inquiry covered a much wider range of services and agencies. A case study approach was adopted for the analysis. Yin (1984:23) describes a case study as "*an empirical inquiry that investigates a contemporary phenomenon within its real-life context.*" This can involve a longitudinal study of a single case but this is not necessarily so. A case study is not intended as a study of the whole organization or system (Yin 1984). Here it is a way of examining the gap between expressions of a commitment to equal treatment and the cultural or organizational realities.

"Community Care" in the late 1980s and early 1990s in the UK

The term "*community care*" came to be used as a short-hand for the impact of the policy of deinstitutionalisation of psychiatric services in the UK. The policy of deinstitutionalisation had its roots in a progressive vision of the replacing the discredited Asylum with community based mental health services predicated on liberal civic values. The reality was far from this vision. As Moon (2000), Wolch and Philo (2000) and Wolff (2005) demonstrate the Asylum was replaced by a fragmented, patchwork of bedsits, poor housing, day centres and homelessness. Knowles' (2000) study of the ways, in which, the "*mad*" negotiate this new urban landscape

highlights the ways, in which, the decline of the Asylum led to a shift from public to private provision of service. As she notes, this is a model that has been increasingly followed for other "*problematic populations*". In addition, the expansion of the penal state (Wacquant, 2009) has seen the mentally ill increasingly drawn into the Criminal Justice System (CJS) (Cummins, 2006). This overall process has been termed "*transinstitutionalisation*". A combination of an idealised rhetoric of community and the fact that the policy was introduced during a period of neo-liberal inspired financial retrenchment and reductions in public service meant that the civic ideals of the challenge to indignities of the Asylum (Barton, 1959, Goffman, 1968 and Martin 1985) were never fully realised (Cummins, 2010). The previous dominant image of the mad: wild madman chained in an asylum, was replaced by that of a homeless, acutely mentally ill man pushing all his belongings in shopping cart around the centre of major cities (Cross, 2010). It should be noted that this imagine was frequently a racialised one. Kelly (2005) has adopted the term "*structural violence*" from Liberation Theology as a means of exploring the impact of race, poverty, homelessness and mental illness on this group.

Drakeford and Butler (2006) have examined the impact that such high profile scandals have on the development of public policy in the social welfare field. The focus of the Government response by successive administrations has been to focus on changing the mental health legislation and policy framework. As with other areas of public service provision, there was a focus on the auditing of professional practice and accountability. These moves culminated in the reform of the Mental Health Act in 2007 and the introduction for the first time in England and Wales of Supervised Community Treatment Orders (CTOs). This allows for the certain groups of discharged patients to be immediately recalled to hospital if they breach conditions – for example, they do not take medication. This sort of

legislation is an increasing feature of the mental health policy landscape. These changes were, partly a result of series of official Inquiries and high profiles cases in this period where discharged patients had committed very serious offences including homicides (Cummins, 2010). Cummins (2013) argues that these developments in the mental health field can be viewed in a similar light to the impact of the media reporting of violent crime on penal policy. In the late 1980s and early 1990s the focus was on legislative solutions rather than an examination of the structural weaknesses of service provision.

Racism and mental health services

The history of psychiatry and mental health services is scarred by racism – i.e. prejudice and discrimination based on the belief that human beings can be classified or divided into distinct biological groups and that these “*races*” possess distinct and inherent characteristics and traits (Kohn, 1996). As Nye (2003) notes in the process of the rise of medicalisation it was minority groups – women, racial and sexual minorities who became the focus of what Foucault (1991) terms “*the disciplinary gaze*”. The legacy of racism remains with us today in the UK. As the *Black Manifesto* (2010) produced by a range of community groups demonstrates this is not just an issue for mental health services. Such discrimination can be found across the delivery of health and public services including, education, health, housing and employment. As Kelly (2005) argues there is a dynamic relationship between these factors and mental health.

In *Breaking the Circles of Fear* (Keating et al, 2002), the ways, in which, many young black men experience mental health services is outlined. The overall view is that this still remains, in too many areas, a coercive rather than therapeutic experience as *Breaking the Circles of Fear* and *Delivering Race Equality* (2005) highlight. This depressing picture of the continued

emphasis on coercion has a much wider impact. Prospero and Kim (2009) explore the ways, in which, this historical legacy and current practice combine to deter black people from seeking help at an early stage. This continues to be a fundamental problem that mental health services, despite a range of policy initiatives have failed to tackle. It is only if professionals openly and honestly engage in debate about these issues that progress can be made.

It is well established that there are significant variations in the experiences of different ethnic groups in mental health services. (Bhui et al, 2003). One of the most consistent findings in the literature is that people of African – Caribbean origin, particularly young men with mental health problems are over-represented in prison populations and secure forensic mental health services (Coid et al ,2002). In addition, this group of patients is more likely to be treated with anti-psychotic medication with fewer in the group be offered psychotherapy or other less medically dominated forms of treatment (McKenzie et al 2001). The causes of these significant differences in health outcomes are complex. It is important to acknowledge the impact of wider societal forces – the social determinants of health which the WHO describes as follows

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.” http://www.who.int/social_determinants/en

Race is clearly a factor that needs to be considered as one of the social determinants as minority communities are marginalised facing increasing

poverty and other barriers, including racism, that will impact on physical and mental health.

Social attitudes to diversity have, on the surface at least, changed significantly over the past thirty years. However, structural factors have been much more resistant to change. This seem to be particularly case in the CJS and forensic mental health services. *The Black Manifesto* (2010), for example found that: forty per cent of patients in the three special hospitals (Broadmoor, Ashworth and Rampton) are of African- Caribbean origin, the average stay for these patients in over nine years and ten per cent of black patients in forensic settings have not committed a crime – they have been admitted to these units from general psychiatric wards (Thornicroft, 2006).It is important to emphasise here that the three special hospitals are national resources. One would not expect the ethnicity of patients to map that of the country but this figures are shocking. In the CJS, the figures provided as strong a picture. The manifesto highlights the fact that African- Caribbean citizens are imprisoned at a rate of 6.8 per 1000 compared to 1.3 per 1000 amongst White citizens. 27% of the UK prison population comes from Black Minority Ethnic background and over two thirds of that group are serving sentences of over four years. Berman (2012) reports that in June 2011 13.4% of the prison population, where ethnicity was recorded was Black or Black British. This group comprises 2.7% of the general population. This is the context for the Inquiries that will be discussed further below. It is not to suggest that other Black and Minority Ethnic (BME) groups do not experience a range of difficulties in accessing appropriate mental health care, for example, women of South Asian heritage (Fenton et al, 1996, Burr, 2002, Gilbert et al, 2004 and Ahmad et al, 2005). However, the problem of

over-representation of black men seems deeply embedded in the CJS and forensic mental health sectors

These problems remain deeply engrained despite policy attempts to tackle them since the period under discussion here. For example, the Race Relations Act 2000 as well as outlawing race discrimination in public authorities not covered by the 1976 Act placed a general duty on public authorities to promote race equality. Delivering Race Equality (2005) was established following the Inquiry into the death of David Bennett. This five year action plan was an attempt to tackle these deep seated issues producing services that were more sensitive to community needs including a target of the recruitment of five hundred community development workers. In 2010, DRE came to an end having failed to reach this target. The discussion of race has been marginalised by an adoption of a much broader "*equalities*" agenda. However, as Omonira-Oyekanmi (2014) recently noted current experiences of young black men within mental health remain very familiar to those of Orville Blackwood and Christopher Clunis. Omonira-Oyekanmi (2014) emphasises that it is still the case that young black men are still more likely to be detained under the MHA, restrained or be highly medicated. These personal experiences are supported by wider evidence from the CQC (2013) and Count Me In (2011).

Orville Blackwood and Christopher Clunis

The following section provides background information on the two young men at the centre of the Inquiries under consideration here. The information is based on that provided at the Inquiries.

Orville Blackwood.

Orville Blackwood was born in Jamaica in June 1960. He moved with his family to the UK as a young child. He became a naturalised British citizen in 1989. Blackwood a number of difficulties at school, he spent a short period in public care and struggled with literacy. As an adult, like a number of young black men in the early 1980s, he found it difficult to find sustained employment. He drifted into petty crime and served short prison sentences.

In his early twenties, Blackwood's mental health began to deteriorate. He began to neglect his personal hygiene and was often aggressive. His mood fluctuated dramatically. His first contact with mental health services occurred in January 1982 when he was admitted to hospital for a short period – he was described as "*acutely disturbed, dishevelled, angry and suspicious*". During this admission, he was threatening towards staff. He was subsequently admitted in August that year following a period where he experienced auditory hallucinations was unable to sleep and was behaving in a bizarre manner. During this admission, he was violent towards staff – he bit a nurse. Over the next four years, there then followed a pattern of repeated short admissions to hospital. On admission, Blackwood was in an extremely manic and agitated state, he was often sexually disinhibited and psychically aggressive towards staff or family members before his admission. Blackwood was consistently seen as a difficult to manage patient – he challenged the authorities but also lacked any "*insight*".

In January 1986, Blackwood entered a local bookmakers' shop and threatened the staff with what appeared to be a gun – it was, in fact a toy. He was arrested immediately and assessed whilst in H.M.P. Brixton. At this point, there was no evidence of any mental illness. For this offence, he was sentenced to three years in prison. Whilst serving this sentence, he was transferred to H.M.P. Grendon Underwood. Grendon is a unique institution in the CJS, prison that is run along the lines of a therapeutic community. On

his transfer, Blackwood was in a paranoid and aggressive state, he also attempted to hang himself. In October 1987, Blackwood was transferred to Broadmoor Special Hospital. Special Hospitals have been established for those patients who represent a "*grave and immediate danger to the general public*". The overwhelming majority of the patients have been convicted of the most serious crimes such as murder, manslaughter or sexual offences. This is not the case for all patients as some are transferred to these institutions because they cannot be managed in normal conditions. The Special Hospital is thus a cross between a high security prison and a psychiatric hospital. Such an environment faces a number of challenges because of the clashes between the aims of a therapeutic approach and the need for the high levels of security. The Special hospitals, because of the notoriety of some of the patients, are always the subject of a high level of media interest. As noted above all, young black men are over-represented in these settings.

As Prins (1994) outlines there was a pattern that developed over the course of Blackwood's admission to Broadmoor. As his symptoms and delusions became more paranoid, he became more aggressive. This led to higher dosages of medication being prescribed and the involvement of large numbers of staff to either restrain Blackwood or inject him with medication. The Prins Inquiry (1994) outlines the way that this pattern appears to have developed into entrenched positions on both sides. There are several further examples given where, in response to disturbed and agitated behaviour, Blackwood is restrained by large numbers of staff, placed in seclusion and then administered cocktails of large doses of medication. Orville Blackwood died in August 1991, at that time he was a patient at Broadmoor Special Hospital. He was the third black patient after Michael Martin and Joseph Watts to die in similar circumstances at the hospital within a seven year period. In September 1991, an Inquiry headed by the

prominent academic Professor Herschel Prins was established and it reported in 1993.

The Inquiry's remit was to "*investigate the circumstances leading to the death of Orville Blackwood*" as well as "*to examine the reports of the Michael Martin and Joseph Watts inquiries to investigate any significant common factors between all three deaths*". All three men had died after having been placed in "*seclusion*". Inquest verdicts of "*accidental death*" were returned. The pathologist in the Blackwood case noted the cause of death as "*cardiac failure associated with the administration of phenothiazine drugs*".

Christopher Clunis

Christopher Clunis was born in Muswell Hill, London in 1963. Clunis did well at school – he obtained six O-levels and was studying for A-levels when he left to pursue a career in music. As a talented jazz guitarist, he found work on in bands on cruise ships. During this period, his parents returned to Jamaica as his mother suffered a stroke. She died in 1985 when Clunis was on tour. It was some time before the family could contact him with the news and he missed the funeral. These events seem to have had a profound and long lasting impact on him. From 1986 onwards, Clunis's mental state seems to have deteriorated significantly. His personal care was poor and he began to dress in a bizarre fashion. He went to stay with a sister but he had to leave when he hit his niece. As the family struggled to support him, he moved to live with his father in Jamaica. It was during this period that he was first admitted to a psychiatric unit – Bellevue Hospital in Kingston.

In 1987, Clunis returned to live in London. It is this period up until his arrest for the murder of a stranger – Jonathan Zito – at a tube station in December

1992 that forms the bulk of the subsequent public inquiry. Clunis's mental health was such that he was admitted to hospital in June 1987. From that point onwards, a depressing pattern emerges of short admissions to hospital followed by an early discharge without adequate support followed by periods of homelessness or living in poor quality hostels. During these admissions to hospital, Clunis had a history of sexually disinhibited and violent behaviour. There were a number of assaults on staff and other patients – including threats with knives and a screw-driver. At no point in this five year period were agencies able to engage successfully with Clunis to tackle the long-standing difficulties that he faced. In this period, community-based mental health services were under tremendous pressure (Cummins, 2010). The factors that caused this, including, high levels of need, under-resourced and poorly organised services and lack of sufficient in-patient beds were finally acknowledged by the New Labour Government in the policy document Modernising Mental Health Services (Dept.of Health, 1998). This document is subtitled – sound safe (emphasis added) and supportive services as and indicator of the political emphasis of the response. When the document was introduced, the then Secretary of State for Health, Frank Dobson announced that *“community care has failed”*

Clunis was found guilty of manslaughter on the grounds of *“diminished responsibility”* in 1993. After his conviction, it was announced that a formal public Inquiry would be held into his care and treatment. Clunis was sentenced under the provisions of the Mental Health Act (1983). Section 37 of that act allows the Court to sentence a person to be detained in a psychiatric hospital. Section 41 allows for restrictions to be placed on the circumstances, in which, an individual can be released – the effect of these conditions is that the individual can only be discharged following a tribunal headed by a judge. This is, in effect, an indeterminate sentence. The *Ritchie*

Inquiry produced its final report in 1994. The terms of reference of the Inquiry were

1. *To investigate all the circumstances surrounding the admission, treatment, discharge and continuing care of Christopher Clunis between May 1992 and December 1992;*
2. *To identify any deficiencies in the quality and delivery of that care, as well as interagency collaboration and individual responsibilities;*
3. *To make recommendations for the future delivery of care including admission, treatment, discharge and continuing care to people in similar circumstances so that, as far as possible, harm to patients and the public is avoided.*

After initial hearings, the Inquiry decided to widen its remit to examine the entirety of Clunis's contact with mental health services.

How do the Inquiries consider the issues of race and racism?

The two inquiries cover major areas of mental health services including community mental health services, all areas of the CJS and forensic mental health services. In addition, it is possible to examine both institutionalised care and aftercare provision, alongside the involvement of other key agencies such as the police. Here, the focus will be on the issues of race and racism. In particular, I am exploring how the Inquiries approached these questions and the possible impact on the nature of the care and treatment provided to Orville Blackwood and Christopher Clunis. There is an enormous body of literature, which explores the issue of race and psychiatry generally and the experiences of young black men in particular. (Browne, 2009 Cope, 1989, Fernando 1988, Fernando et al 1998 Ndegwa and Olajide, 2006, Prospero and Kim, 2009 and Sainsbury Centre for Mental Health

2006) Both the Inquiries considered the possible impact of racism in these two cases. However, the approaches that they took were almost diametrically opposed.

The Prins Inquiry

From its ironic and iconic title onwards, the Prins Inquiry into the death of Orville Blackwood was forthright in its criticism on the ways that young black men were treated by the CJS and psychiatric systems. One of the reasons for the establishment of Professor Prins' inquiry was to look again at the previous investigations into the deaths of Michael Martin and Joseph Watts. Both these inquiries concluded that there was *"no direct evidence of racism at Broadmoor"*. The *Prins Inquiry* (1994) felt that *"the interpretation is based on some very crude measures of racism"* for example, reported incidents of direct racial abuse or the use of racial epithets. The Inquiry reported that many of the features of a modern public service such as an Equal Opportunities policy, ethnic monitoring and service-user involvement were absent. The Inquiry members were shocked when they were told that basic information such as the number of black patients was not collected in any systematic fashion.

The phrase *"big, black and dangerous"* is a short-hand that the Inquiry uses for the ways, in which, Orville Blackwood and other black patients were viewed. It is not a phrase that the Inquiry invented; it was one that was openly used amongst nursing staff. One of the major manifestations of this culture was on the impact on the response to any signs of distress that black patients exhibited. There was an emphasis on seclusion and physical restraint involving large numbers of staff. Patients such as Blackwood were prescribed unusually high dosages of medication. The Inquiry notes that the

way, in which, the wider organisational culture created a very hostile environment where it was difficult to establish therapeutic relationships.

A contrasting view of Orville Blackwood as a patient and individual was presented to the Inquiry by one of the doctors involved in his care. On p17, (Prins, 1994) Dr. Burke – a black psychiatrist suggested that Blackwood was *“not a without insight, rather he was a man with profound insight”*

Blackwood consistently argued that he was being held in custody long after the expiry of his prison sentence. This was clearly the case as he would have been released from his original three year prison sentence long before August 1991. This claim was seen as evidence of his ongoing mental illness. It was a common theme in the construction of the *“big, black and dangerous”* stereotype that patients such as Orville Blackwood believed that they were only detained because of racist stereotyping not because of their mental health condition justified it. There is a fundamental issue of jurisprudence being raised here – the overlap of psychiatric and the CJS creates cases such as this one (Prins 2010). Seddon (2007) argues that this overlap has always and will continue to exist because the categories of *“offender”* and *“patient”* are not fixed but fluid and permeable entities that are the creation of cultural, social and political views.

The Ritchie Inquiry

The Ritchie Inquiry adopts a very different view of the possible impact of race on the care and treatment of Christopher Clunis. The Inquiry team’s view is outlined explicitly at the beginning of the final report

“We have tried throughout our investigations to keep a close eye on any evidence of prejudiced attitudes towards Christopher Clunis. We have asked witnesses for direct and indirect examples of racial discrimination which

could have affected his care and treatment. We record no example of such prejudice or discrimination has become apparent to us, save for the possibility of too great a willingness to accept that he abused drugs."

The report, therefore, does not discuss these issues in any depth. Such a "colour blind" approach ignores or down plays the individual, cultural and ethnic heritage as part of the explanation for the failure to provide adequate mental health care to Mr Clunis.

Discussion

Following the murder of a black teenager Stephen Lawrence in London in 1993 and failures of the police in investigating the crime, a public inquiry was established. The judge who headed that inquiry, Lord Macpherson found that the Metropolitan Police had been guilty of "institutional racism". The Inquiry defined the term as

"The collective failure of an organisation to provide an appropriate and 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." The Stephen Lawrence Inquiry (1999),

The failings of the regime at Broadmoor at that time of the death of Orville Blackwood surely met the criteria for "institutional racism". The result was all the creation and maintenance of a culture, in which, black patients who gave evidence to the Inquiry, made it clear that they felt in physical danger. There were clear cultural difficulties between the almost totally white staff

group and patients from ethnic minority groups. This is exacerbated by the profession of psychiatry and the background issues related to race outlined above. As the Inquiry notes psychiatry is a "*white middle class profession*" and that "*the social perspective is often missing when psychiatrists diagnose psychiatric patients from poor, black African- Caribbean communities*".

The *Ritchie Inquiry* provides examples of the ways that the "*big black and dangerous*" stereotype permeated services. There are several interlinked elements here. As with Blackwood, there was an emphasis on physicality - accounts of Christopher Clunis frequently refer to "*his considerable height and powerful build*". The point here is that is introduced without any further comment – it is not clear how it is relevant to the provision of services or decisions about his mental health care. There are other similarities with the Blackwood case. For example, the cause of Clunis's problems was seen as abuse of marijuana. In the late 1980s, cannabis induced psychosis was a very common diagnosis in the cases of young black men in contact with mental health services. In addition, the fact that both Clunis and Blackwood were given a series of diagnoses is another well-documented feature (Fernando, 1988) of the black experience of psychiatric services. In his evidence into the death of Orville Blackwood, Dr Burke considered this issue of diagnosis – he did not accept that Blackwood was suffering from schizophrenia. In essence, he argued that the African-Caribbean young men that he met in the course of his work, as a result of the wider problems that they faced, were often very insecure. However, this was hidden by a series of projections and challenges to authority that were often interpreted as a form of paranoia. This was then constructed as an illness via the prism of deeply engrained racist stereotypes that emphasised the physicality of young black men.

There is one area of where there is significant difference in the approach to both men: *violence*. In the Blackwood case, at no time was there any attempt to minimise the potential for violent or aggressive behaviour. As the *Prins Inquiry* notes, this hypervigilance was a contributory factor to the series of violent incidents that occurred. The repeated use of seclusion and administering medication using large numbers of staff created a climate of fear rather than the building of a “*therapeutic alliance*”. In the Clunis case, there a series of examples where violence is downplayed or minimised in reports to other agencies. The reasons given are that staff think other agencies will see Clunis as “*big, black and dangerous*” if they are given this information. Thus very relevant information regarding incidents of threats and assaults on staff and other patients is not shared. It certainly did little to assist Clunis who was clearly in need of long-term support to tackle the deeply entrenched problems that he experienced. It also put other people at risk. This is an example of the corrosive effects of institutional racism. It appears that staff felt that they risked being accused of racism, if they raised the issue of Clunis’s past violent behaviour.

One of the most shocking areas of both reports is the treatment of the relatives of the two men. This reflects a series of long held historical views that pathologises the “black family”. In the case of Christopher Clunis, as the *Ritchie Inquiry* (para 3.1.6.) puts it: “*They treated him as single, homeless and itinerant with no family ties, the more they treated him as such the more he began to fulfil that role*”. Few, if any, attempts were made to contact his sister. Agencies were shocked to discover that she existed and had been in fairly regular contact with her brother in the period prior to the murder of Jonathan Zito. The *Prins Inquiry* noted that the treatment of the Blackwood family in the aftermath of their son’s death was disgraceful. There were no clear procedures for informing the family. When his mother eventually was able to see her son’s bodies, it was in a refrigerator at the

mortuary and she was able to see other bodies at the same time. The Inquiry panel, appalled by this evidence, specifically visited the mortuary to confirm that this was the case.

The marginalisation of family members and the refusal to be open about the events that led to their loved ones death, has been a feature of the authorities response to a series of deaths of black people in police custody, prison or psychiatric units. For example, Joan Bennett the sister of Rocky Bennett campaigned vigorously for a public inquiry into her brother's death. Rocky died in circumstances not unlike those of Orville Blackwood being restrained by staff whilst a patient in a secure psychiatric facility (Blofeld, 2004). Part of the official policy response to such issues has been the establishment of Independent Advisory Panel on Deaths in Custody. The panel's work covers all forms of custody including mental health facilities. It is currently developing an "*equalities project which will focus on understanding the evidence around proportionality and deaths in custody of BME offenders*"

Conclusion

Wacquant (2005, 2009, and 2009) has highlighted the ways, in which, the dynamics of race have been recast in the era of mass incarceration and the post-Keynesian, deregulated economy and state. The two Inquiries approach the issues of race and racism from completely different perspectives. The *Ritchie Inquiry* does not engage with the idea that racism by individuals or organisations may have had an impact on the care or treatment that Christopher Clunis received. It seems unsustainable to believe that race played no part at all in the failure of services or that Clunis never encountered racist behaviour. Professor Prins' report is a much more radical document. It documents and confronts racist attitudes and behaviour that existed at Broadmoor at the time. The report outlines an

institutional culture that took little, if any real account of the individual, social and cultural needs of its black patients or their families. The final report is a damning indictment of the corrosive effects of a failure to challenge and tackle such behaviour.

Psychiatry, along with the CJS agencies has played a key role in creating the racist stereotype of the psychically aggressive violent black male. The reporting of the Clunis case (Cummins, 2010) was an example of this process. In addition, as Ellis and Davis (2001) argue the failings of community care were partly due to its construction as a way of managing the "*dangerous other*", which it failed to do. The "*other*" was largely constructed in a racialised and gendered form (Neal, 1994). As Garland (2001) suggests the moves away from a rehabilitative approach means that the "new penology" places a great emphasis on public protection and incapacitation. Risk and its management have come to be one the dominant drivers of the development of mental policy, legislation and service structures. Turner and Colombo (2008) go as far to that risk rather than care has become "*defining feature of service-user contact*". In Bourdieu's (1999) terms mental health services have become very much part of the "*Right hand*" rather than the "*Left hand*" of the State with a focus on the management of marginalised groups rather than the tackling of inequality, poverty and discrimination. This marginalisation is likely to increase as the politics of austerity become more firmly entrenched with the subsequent reduction in community services. Poor and marginalised communities are more reliant on these services so the impact of cuts disproportionately falls on them. For example, Black Mental Health UK (www.blackmentalhealth.org.uk) reported in April 2015 that funding for,

Family Health Isis London's oldest black led mental health service had been cut just at a time when demand was increasing.

These Inquiries both take place at the interface of the CJS and Mental Health systems. Both these systems continue to marginalise large numbers of young black men. As Gilroy (2002) notes the 1970s crisis in legitimacy of the welfare state led to a reconfiguration in the ways that the image of young black men was constructed by the State with an emphasis on the alleged physical threat that they posed. The policing of black communities has continually constructed them and particularly young, male members as a threat to social order (Hall et al., 1978) Warner and Gabe (2004) argue that part of the social processes that led to the marginalisation of groups is that these groups are seen as "*other*". Thus the "*other*" also becomes associated with risk. Risk in the mental health and CJS is always the risk that that individual is seen to pose to the wider society. It is never constructed in terms of the risk that services or systems pose to individual's (Kemshall, 2002).

The final question that arises is whether these documents are simply historical events, interesting in and of themselves but with no significance or relevance for modern mental health professionals in the UK. As *Breaking the Circles of Fear* (Keating et al, 2002) argues it is impossible to understand the current context of mental health services and their relationship with minority ethnic communities unless one understands the historical background. Despite policy initiatives, there are ongoing concerns about the deaths of black men in mental health and CJS. The recent inquiry by Lord Adebawale (2013) into mental health and policing was initially commissioned following the death of Sean Riggs in police custody. Lord Adebawale took the decision to broaden the scope of the inquiry. The

campaign by Sean Riggs family is another example of family members have to struggle with public bodies such as the police or mental health trusts to get answers about the circumstances of the death of a loved one whilst at the same time coping with a traumatic loss. The courage and determination of the families and their supporters should never be underestimated. At the time of writing, the inquest is beginning into the death of Kingsley Burrell. Mr Burrell was detained by police officers under section 136 MHA following an incident at a shop in Birmingham in March 2011. He was then admitted to hospital. He died whilst being restrained by both medical staff and police who had been called to the ward (www.inquest.org.uk). His sister, like the families of David Bennett and Sean Riggs has struggled for justice. It is clearly unacceptable that it takes four years for an inquest hearing to take place,

These Inquiry reports are two of the major documents in that process – Prins used the term “*big, black and dangerous*” because the Inquiry team had heard it used by staff but also because it encapsulates the racist stereotyping of young black men. The danger is the context of that use will be lost and it becomes used in a way that is totally contrary to the author’s intentions. As Thomas (2012) mental health services are not provided in a vacuum. He argues that “*schizophrenia is emblematic of the oppression and mistreatment of black people by psychiatry*”. The Inquiries that have been examined here present polar opposite views of the problem of race, psychiatry and racist stereotyping. The Ritchie Inquiry tries to set aside or minimise the impact of cultural or racial factors in seeking to explain the history of Christopher Clunis’s contact with services. This individualised approach does not provide a sufficient explanation of the wider context of young black men’s experience of mental health services. Prins, on the other hand, confronts these issues head on with a clear message that this is what *all* mental health professionals should do.

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