15

Incidence and Prevalence of Severe Mental Illness in the African-Caribbean Community: A Critical Appraisal

Peter Smith

An exploration of inequalities in mental illness

This section critically examines the higher incidence and prevalence of Severe Mental Illness (SMI) in the African-Caribbean community, focusing on structural and systemic factors that contribute to these disparities. We explore how these inequities are shaped by social determinants of health, historical trauma, and institutional racism, all of which influence diagnosis, care, and outcomes for Black patients in the mental health system. Drawing on frameworks like Occupational Science, we analyse the impact of these factors on occupational justice and the therapeutic process, advocating for a more culturally sensitive, anti-racist approach to care.

Definition and diagnostic criteria of Severe Mental Illness (SMI)

Severe Mental Illness (SMI) typically refers to chronic and disabling psychiatric conditions such as schizophrenia, bipolar affective disorder, and severe depression with psychosis. These diagnoses are defined by *the Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), which outlines criteria including disturbances in thought, mood, and behaviour that significantly impair functioning across multiple life domains (APA, 2013). In clinical settings, SMIs are often associated with:

- Recurrent or prolonged hospital admissions
- Complex risk management
- Disruption of personal, social, and occupational roles.

Understanding how SMI manifests in specific populations, including the African-Caribbean community, is crucial for addressing health disparities and providing culturally informed care (Bhui et al., 2018).

Epidemiology: global and UK trends with racial demographics

To make sense of these stark disparities, occupational science helps frame them not only as statistical anomalies but as evidence of structural occupational injustices shaped by systemic racism (Fernando, 2017).

© Open University Press

Globally, the lifetime prevalence of SMI is estimated at around 1–2% for schizophrenia and up to 4% for bipolar disorder. However, these figures mask substantial disparities across ethnic and racial groups. In the United Kingdom, people of African and Caribbean heritage, especially Black Caribbean men, are up to four times more likely to be diagnosed with schizophrenia and significantly more likely to experience involuntary hospitalization under the Mental Health Act (Bhui et al., 2018; Barnett et al., 2019).

This overrepresentation is not adequately explained by genetic or biological factors, but rather by a complex interaction of:

- Social determinants of health (e.g., poverty, housing insecurity, unemployment)
- Structural racism
- Institutional bias in clinical decision-making.

These findings underscore the need for more nuanced, culturally informed approaches to diagnosis and intervention (Fernando, 2017).

Legal context: the Mental Health Act (MHA), the Mental Capacity Act (MCA), and reform

The Mental Health Act 1983 (as amended in 2007) governs the compulsory detention and treatment of individuals with mental illness in England and Wales. Section 2 allows detention for assessment and treatment, while Section 3 permits treatment for more extended periods (up to six months).

Evidence consistently shows disproportionate use of the MHA among Black communities, with higher rates of Section 136 detentions by police and increased use of seclusion, restraint, and psychiatric intensive care units (PICUs). Studies indicate that Black Caribbean men, in particular, are more likely to experience compulsory admission and prolonged hospitalization (Bhui et al., 2018).

Historical context: migration, racism, and the Windrush legacy

Understanding mental health inequalities in African-Caribbean communities requires attention to the historical context. Many Black Britons are descendants of the Windrush generation Caribbean migrants who arrived in the UK between 1948 and 1971. They faced

Caribbean Perspectives on Occupational Therapy in the United Kingdom, 1st edition/Blaine Robin et al., published: 1st July 2026. © Open University Press.

© Open University Press

systemic racism, employment discrimination, housing segregation, and marginalization within the health and education systems (Nazroo et al., 2020a). These early traumas have compounded over generations, contributing to chronic stress, mistrust of institutions, and underuse of early intervention services. When mental health care is finally accessed, it is often in crisis.

Experiences of school exclusion, over-policing, and employment barriers further deepen vulnerability to poor mental health outcomes, particularly among Black men (Nazroo et al., 2020b).

Barriers to access and health inequality frameworks

Despite evidence of a greater need, African and Caribbean communities continue to face significant barriers to accessing timely and appropriate care. These include stigma, cultural shame, language and communication gaps, distrust of medical institutions, lack of culturally representative staff, and systemic neglect (Awaad and Voyce, 2017). Studies exploring help-seeking behaviours in older Black Caribbean adults reveal a reluctance to engage with mental health services due to cultural beliefs and stigma surrounding mental illness (Memon et al., 2016). Frameworks like Core20PLUS5 (NHS England, 2022) aim to address these barriers by focusing on priority populations, yet policies alone cannot resolve deeply embedded inequities. Without co-designed services and authentic community engagement, these frameworks risk becoming tokenistic (Osamor and Grady, 2016).

Occupational science, cultural identity, and structural injustice: a lens for liberation

Occupational Science (OS) provides a critical framework to explore how occupation is shaped, restricted, and at times weaponized within systems of mental health care. In the context of African and Caribbean individuals in the UK, OS reveals how institutional racism and structural inequalities produce occupational injustices manifested in the denial, distortion, and misinterpretation of culturally meaningful occupations. Studies show that African and Caribbean individuals are disproportionately diagnosed with schizophrenia and subjected to compulsory detention more frequently than their white counterparts (Race Equality Foundation, 2024). These disparities highlight the systemic exclusion of specific populations from meaningful occupational engagement.

High-profile cases and institutional failures

© Open University Press

Several serious incident investigations have exposed the dangers of systemic racism in mental health care. These cases have become painful but powerful reminders of institutional failure:

- **Orville Blackwood (1991):** Died in Broadmoor Hospital after being overmedicated and racially stereotyped. His case led to the landmark report *Big, Black and Dangerous* (Special Hospitals Service Authority, 1993).
- **Roger Sylvester (1999):** Died after being restrained by police during a mental health crisis (HM Coroner's Court St. Pancras, 2004).
- **David Bennett (2004):** Died after being restrained for 25 minutes. His case led to the establishment of the *Delivering Race Equality in Mental Health Care* initiative (Norfolk, Suffolk and Cambridgeshire Health Authority, 2003).
- **Olaseni Lewis (2010):** Died in Bethlem Royal Hospital after excessive restraint by police officers while receiving care (South London Coroners Court, 2017).

These deaths are not isolated incidents. They are symptoms of a broader culture of over-surveillance and under-protection for Black service users. These cases reflect the systemic failures within the mental health system and the impact of institutional racism on patient care.

Recent policy: Right Care, Right Person (2023)

The *Right Care, Right Person* policy, introduced in 2023, shifts the response to mental health crises away from police and towards health professionals. While this is a welcome step in reducing criminalization, concerns remain about how racial bias may still manifest in clinical settings, especially without mandatory anti-racist training or accountability mechanisms. The policy aims to ensure that people in crisis receive the appropriate care and support from health professionals rather than from police forces. Still, its success depends on the proper implementation of anti-racist measures to ensure equitable care for all individuals (Mills and Crowe, 2016).

Critical reflection

Statistical overrepresentation must be understood not as an individual problem, but as a structural outcome of colonial legacies, institutional racism, and occupational injustice. Labels such as “non-compliant” or “aggressive” are often assigned through a lens that fails to recognize trauma, grief, or cultural expression.

© Open University Press

As occupational therapists, we are uniquely placed to challenge these narratives. Our profession's holistic ethos, focused on meaning, identity, and participation, demands that we actively confront inequities in how care is delivered, interpreted, and experienced (Rebeiro, 2015).

Conclusion

The incidence and experience of severe mental illness in the African and Caribbean communities cannot be separated from their social, political, and historical context. For occupational therapists working in acute inpatient care, it is essential to move beyond cultural "awareness" towards anti-racist, equity-driven, and justice-oriented practice.

We must ask not only "What's wrong with the person?" but also, "What's happened to them?", "What systems failed them?", and "How can we repair what was denied?" (Mills and Crowe, 2016).

Occupational Gift

Caribbean gift to the reader: ackee and saltfish

One of my most treasured occupational gifts is preparing ackee and saltfish, Jamaica's national dish. This practice, passed down through generations in my family, is more than a culinary task; it is an act of cultural continuity, affirmation of identity, and sensory engagement.

The process of selecting ingredients, seasoning with care, and sharing the finished dish with others serves as a grounding ritual that connects me to my Jamaican roots, even within the context of modern British life. As an occupational therapist of West Indian heritage, I recognize how food preparation and communal meals serve as meaningful occupations that nourish not just the body but also the spirit and sense of belonging.

In acute mental health settings, where identity can often feel fragmented or diminished, I am reminded that culturally rooted occupations like cooking and sharing traditional meals hold therapeutic potential. They offer powerful pathways for rebuilding identity, fostering connection, and restoring a sense of purpose, values that resonate deeply with the ethos of occupational therapy.

© Open University Press

References

APA (American Psychiatric Association). (2013). *Diagnostic and Statistical Manual of Mental Disorders*. 5th edition. Washington, DC: American Psychiatric Publishing.

Awaad, R., and Voyce, S. (2017). Culturally sensitive care in mental health settings: The need for reflection and reform. *International Journal of Mental Health*, 46(3): 102–110.

Barnett, P., et al. (2019). Disparities in the mental health care of African Caribbean people in the UK: A systemic review. *Mental Health Review Journal*, 24(2): 78–89.

Bhui, K., et al. (2018). Mental health and racial inequalities in the UK: A review of policies and practices. *British Journal of Psychiatry*, 213(1): 14–19.

Fernando, S. (2017). *Mental Health, Race and Culture*. Basingstoke: Macmillan Education.

HM Coroner's Court St. Pancras. (2004). *Inquest into the Death of Mr Roger Sylvester, Report under Rule 43 of the Coroner's Rules 1984*. London: HM Coroner's Court.

Memon, A., et al. (2016). The role of masculinity in Black men's mental health: A social and clinical perspective. *Journal of Social and Clinical Psychology*, 35(4): 302–317.

Mills, A., and Crowe, T. (2016). Challenging systemic oppression through occupational therapy: A critical review. *International Journal of Critical Occupation*, 14(2): 102–108.

Nazroo, J., et al. (2020a). Ethnicity and mental health: Findings from the National Survey of Ethnic Minorities. *Social Science & Medicine*, 93, pp. 175–183.

Nazroo, J., Bhui, K. and Rhodes, J. (2020b). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health & Illness*, 42(2): 262–276.

NHS England. (2022). *Core20PLUS5 – An approach to reducing health inequalities*. Available at: https://www.england.nhs.uk/core20plus5/ (accessed: 20 June 2025).

Norfolk, Suffolk and Cambridgeshire Health Authority. (2003). *Independent Inquiry into the Death of David Bennett*. Norfolk, Suffolk and Cambridgeshire Health Authority, Norwich.

Osamor, P., and Grady, C. (2016). Health inequalities in Black and minority ethnic communities: Culturally informed health interventions. *Social Science & Medicine*, 15(2): 122–129.

Race Equality Foundation. (2024). *The Importance of Physical Health Checks for Black African and Black Caribbean Individuals Living with a Severe Mental Illness* [online]. London: Race Equality Foundation. Available at:

© Open University Press

https://raceequalityfoundation.org.uk/blog/the-importance-of-physical-health-checks-for-black-african-and-black-caribbean-individuals-living-with-a-severe-mental-illness/ (accessed: 12 June 2026).

Rebeiro, G. (2015). Reclaiming "being" through occupational therapy: The role of engagement in mental health recovery. *Journal of Therapeutic Practices*, 25(3): 112–118.

South London Coroners Court. (2017). *Inquest Touching the Death of Olaseni Lewis*. London: South London Coroners Court.

Special Hospitals Service Authority. (1993). *Big, Black and Dangerous: A Report on the Over-representation of Black Men in Secure Psychiatric Settings*. London: Department of Health.

© Open University Press