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Purpose

This session begins by celebrating Black resilience and leadership for Black History Month, then explores how to advance race equity and anti-racism through the PCREF systematic approach.

Participants will build on pre-learning to:

- Deepen understanding of how racism shapes experiences and outcomes in mental health care
- Reflect on lived experiences
- Explore how data, dialogue, and collective action can drive meaningful change across wards, organisations, and systems

Black History Month: Resilience and Leadership

TIMELINE

1993

Stephen Lawrence

Macphearson Report published

1999

Race Relations amendment

2000

Britain paid off slave owner debt

2015

2016

Nationwide Shutdown

Windrush scandal

2018

WHO AM I?

A

B

C

D

E

DARCUS HOWE

TRINIDAD 1943 – LONDON 2017

- **Mangrove Nine protestor**
- **BBPM member**
- **Race Today editor**
- **Race Today Collective**
- **Battle of Lewisham leader**

ALTHEIA JONES-LECOINTE

1945 TRINIDAD

- **UCPA Universal Coloured Peoples Association member**
- **BBPM leader 1960s – 1970s**
- **Mangrove Nine protestor Notting Hill**

Global Black Thrive

LOUIS MAHONEY

THE GAMBIA 1938 – 2020 LONDON

- Anti racist activist and long-time campaigner for racial equality in the acting profession
- Successfully lobbied to rename Coloured Actors Committee – Afro Asian Committee
- Founded Performers Against Racism
- Led South African challenge against performance apartheid

OLIVE MORRIS

1952 – JAMAICA – LONDON 1979

- Community leader
- BBPM –Youth Section Sisters Collective, BBWG Brixton Black Womens Group
- Black Liberation Organisation, Race Today Collective
- Old Bailey Three
- Squatters rights 121 Railton Road

Global
Black Thrive

MAVIS BEST

1939 JAMAICA – 2022 LONDON

- Grassroots social activist
- Led Scrap SUS Law

Strength and Resilience

The collective fight of **Anti-Black and Anti-Racist** activism is a continuous yet relentless deep-rooted struggle for social justice equality equity and liberation.

It has many unrecognised and unsung notable individuals, who have broken barriers and paved clearer paths of passage for others to tread and take on old and new challenges occurring from racism globally and locally.

This battle is far from over, but we stand firm in the face of all adversity pertaining to this taking courage and motivation from our great contributors past and present.

INJUSTICE ANYWHERE IS A THREAT TO JUSTICE EVERYWHERE

-DR MARTIN LUTHER KING JR.
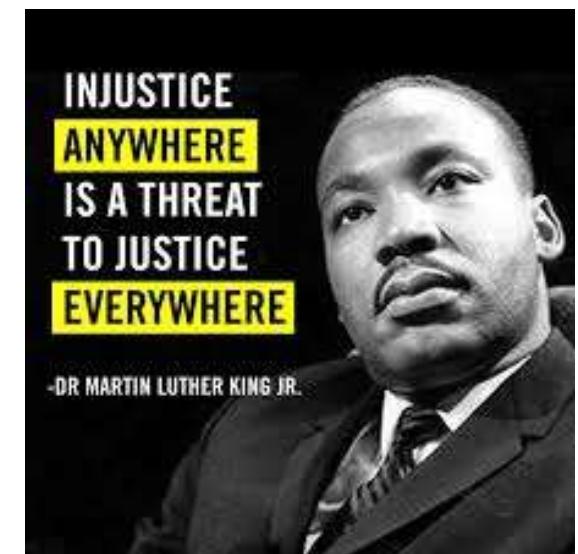
Language & Definitions

Language & Terminologies

- Language, much like culture, is fluid.

- As such, words that were previously commonly used and viewed as acceptable, are now seen as inappropriate, harmful, oppressive and obsolete.

- Phrases such as "BAME", "Ethnic Minorities", "Ethnically diverse", "Multi-ethnic" are now seen as outdated.

- The Lancet (Using the right words to address racial disparities in COVID-19) suggests using the term **Racially Minoritised People** to refer to groups of people stratified as racially inferior.

So what is culture and why is it important?

Culture itself is not fixed to any single identifying factor.

- Culture considers the complex factors that play important roles in shaping a person's identity, such as environment, class, family structure, media, hobbies, socioeconomics, and of course, familial heritage.

How does this relate to the Culture of Care?

- Organisations and institutions have cultures.
- Some of these cultures are racialised, meaning that racism is part of these cultures.
- These racialised cultures should be dismantled to ensure equity in care.
- **This is why anti-racism is so important.**

The Intersectionalities of Racism

Building on the 3 I's of Oppression (Institutional, Interpersonal, Internalized)
Racism rarely acts alone, It intersects with other systems of power and identity.

- Intersectionality (Crenshaw, 1989) shows how race overlaps with gender, class, disability, sexuality, and more.

- Racism can intensify when combined with other biases — e.g. Black women or disabled Black people face unique barriers.

- Institutions often ignore these overlaps, creating policies that don't meet everyone's needs.

- Taking an intersectional lens helps us see the whole person, not just one identity or issue.
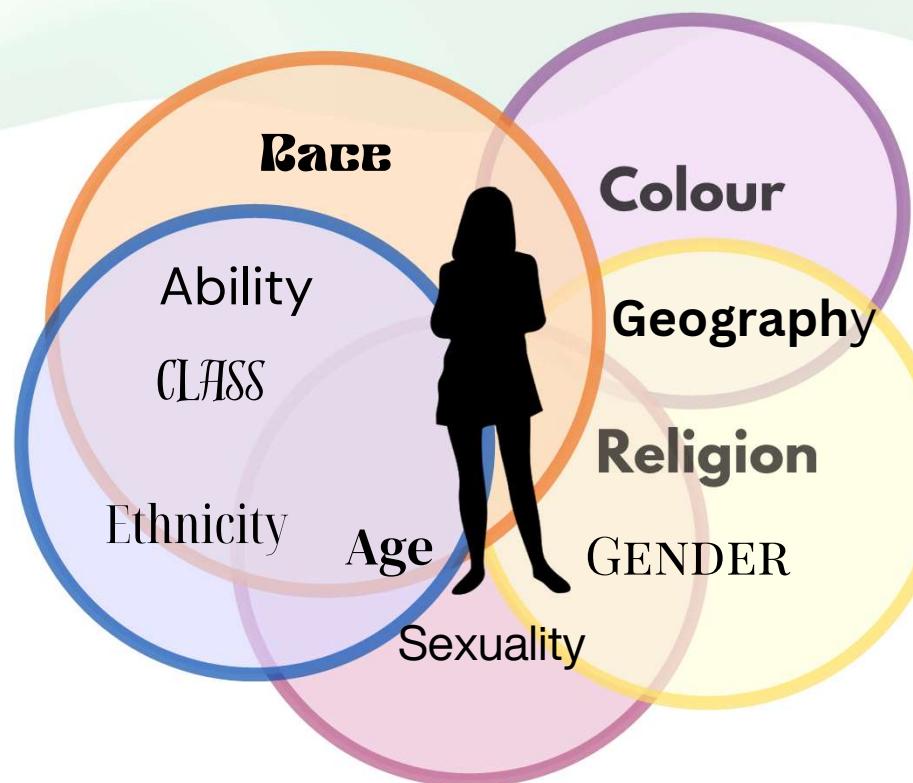
"Who is most affected when we don't consider intersectionality?"

Race · Colour · Geography · Religion · Ability · CLASS · Ethnicity · Age · GENDER · Sexuality

Break

Big, Black & Dangerous (*BBD*)

"Big, Black and Dangerous": Origins and Ongoing Impact

"Big, Black and Dangerous became a label that justified control rather than care" (Orville Blackwood Report, 1993).

The Orville Blackwood Report (1993):
Inquiry following the deaths of Orville Blackwood, Michael Martin, and Joseph Watts at Broadmoor Hospital.

- Official title: **"Big, Black and Dangerous?"** – Report of the Committee of Inquiry into the Deaths in Broadmoor Hospital of Orville Blackwood.
- Found that racism and stereotyping influenced how Black men were perceived and treated in secure psychiatric care.
- Highlighted a pattern where Black patients were labelled as **"aggressive," "uncooperative,"** or **"dangerous,"** leading to coercive treatment and neglect.

Why It Matters Today

- The phrase **"Big, Black and Dangerous"** became a symbol of institutional racism in mental health systems.

- Revealed how fear and bias can replace empathy and therapeutic care.

- Serves as a critical foundation for today's race equity work and the development of the Patient and Carer Race Equality Framework (PCREF).

- Provides historical context for the Christopher Clunis case, which further exposed systemic failures to address racial inequality and stigma.

The Myth of "Big, Black, and Dangerous"
How One Story Shaped a System

What Happened

- Diagnosed with schizophrenia
- Failed by multiple agencies – no single accountability
- Exposed dangers of uncoordinated care
- Led to the **Care Programme Approach (CPA)**
- Introduced structured care plans and named coordinators

System & Society Then and Now

- The "Big, Black, and Dangerous" label shifted focus from system failure to racial fear
- Media coverage reinforced stigma and public panic
- Mental health policies prioritised **public protection over patient rights**
- Despite better coordination today, **cuts and racial bias** still drive poor outcomes
- Trauma from forced treatment continues for many Black men

"Media headlines called Clunis a 'mad killer,' fuelling the myth of the 'Big, Black, and Dangerous' man."

(1992 → Now)

Challenging the BBD Myth
(Big Black & Dangerous)

- Stereotypes like *"Big, Black, and Dangerous"* can deeply harm confidence, wellbeing, and how people are treated.

- These ideas trace back to slavery and Jim Crow, where Black men were falsely depicted as violent "brutes" to justify control and abuse.

- Today, the same narratives show up through racial profiling, police violence, and bias in workplaces, schools, and media.

Key psychological effects

Internalised Stereotype Threat

Self-Doubt & Hyperawareness
Constantly being perceived as a threat can lead to anxiety about one's movements, tone, and presence in public spaces.

Overcompensation
Some may feel pressured to appear overly friendly, soft-spoken, or non-threatening to counteract the stereotype, leading to emotional exhaustion.

Racial Trauma & Chronic Stress

Hypervigilance
Always being seen as dangerous can lead to a state of heightened alertness, similar to PTSD symptoms, due to fears of racial profiling, police violence, or social rejection.

Anger & Frustration
The injustice of being unfairly judged can cause resentment, helplessness, or rage, especially when coupled with experiences of discrimination

'Big, Black, and Dangerous' (BBD) to 'Acute Behavioural Disturbance' (ABD):

How stereotypes shift but still cause harm…

Modern Echoes of BBD:

'Acute Behavioral Disturbance' (ABD)

It was claimed that Black and other ethnic minority groups could exhibit superhuman strength, have a higher pain tolerance, an elevated heart rate, and heightened aggression, often assumed to be caused by drug use. **This was used to justify the use of more severe restraint methods.**

(Care Quality Commission, 2018)

Rising Use of ABD in Mental Health Records (UK)

Mentions of *acute behavioural disturbance (ABD)* in mental health assessments have risen sharply, especially from 2019–2021.

A 2023 study found a 5.4x increase over 15 years in an NHS trust.

(BJPsych Open, 2023)

Key Takeaways

- Racial trauma is often overlooked because racism itself is normalised or denied. Recognising it helps validate the experiences of marginalised groups and promotes healing.

- Being labelled as "big, Black, and dangerous" is not just a social issue but a psychological burden that requires systemic change and individual healing.

- Cultivating self-love, seeking therapy (particularly from culturally competent professionals), and challenging stereotypes can help mitigate these effects.

- culturally appropriate partners can break down the stigma within the system leading to better outcomes for marginalised groups

From Data to Dialogue to Action:

Bridging Gaps in Racialised Experiences
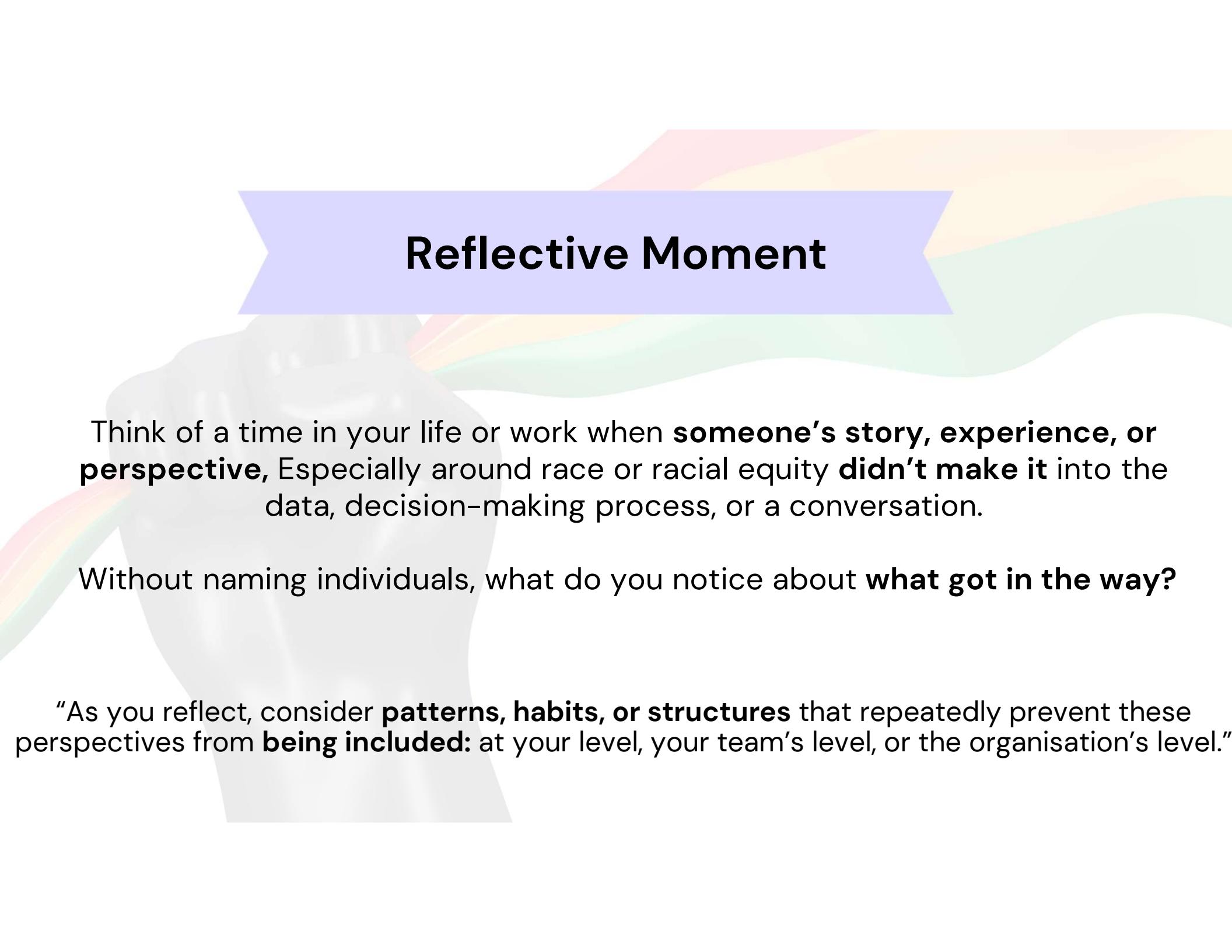
Reflective Moment

Think of a time in your life or work when **someone's story, experience, or perspective,** Especially around race or racial equity **didn't make it** into the data, decision–making process, or a conversation.

Without naming individuals, what do you notice about **what got in the way?**

"As you reflect, consider **patterns, habits, or structures** that repeatedly prevent these perspectives from **being included:** at your level, your team's level, or the organisation's level."

What's visible in data is only a part of the full picture.
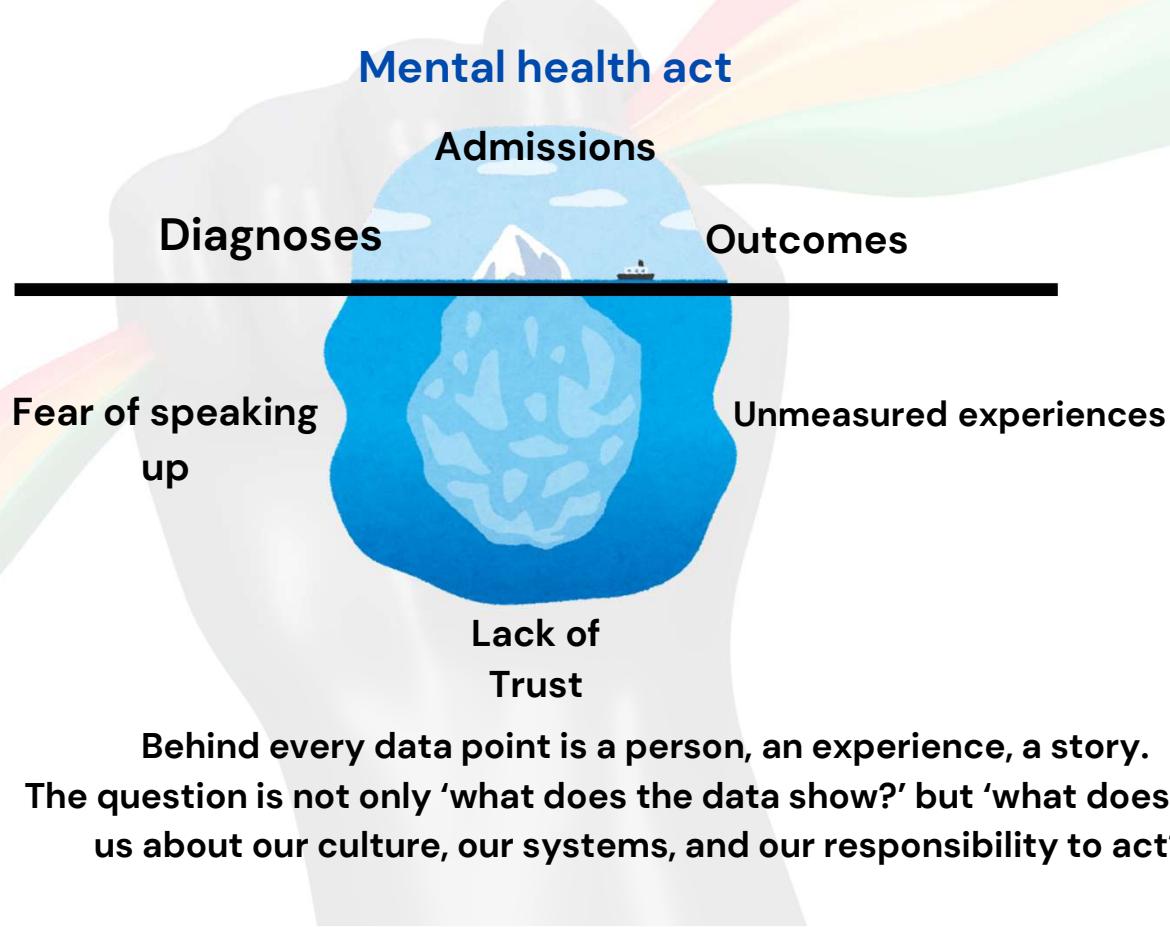
Black and racialised groups especially Black African and Black Caribbean people are 4 x more to be detained & far more likely to enter mental health services through coercive routes, such as police or crisis detention

Black patients are over **50%** more likely to be prescribed injectable antipsychotic drugs than White patients *(Nazroo, 2019).*

The largest increases in the use of Community Treatment Orders and Section 136 detentions have occurred among Black or black British compared with the previous year *(NHS Digital, 2024–2025).*

Mental health act

Admissions

Diagnoses

Outcomes

Fear of speaking up

Unmeasured experiences

Lack of Trust

Behind every data point is a person, an experience, a story.
The question is not only 'what does the data show?' but 'what does it tell us about our culture, our systems, and our responsibility to act?'

Further Information
Link to:Considering Racial Equity and Risk Assessment in Mental Health Services
https://youtu.be/OQrEKA3lboM

When Data Falls Silent

If you don't trust the system to respond fairly, silence can feel like self-protection.

What if silence isn't the absence of experience but the result of not feeling safe to be heard?

Invisibility is Itself a Form of Harm.

Gaps in stories or data reveal were Inequity, Inequality, and hide Harm.

- Combining quantitative and qualitative insights uncovers barriers and opportunities for change.

- Qualitative insight and methods helps moves to uncover deeper insights and adds richer detail to lead to meaningful action

- Informs PCREF: leadership, competencies, and evidence-driven systemic action

Lived & Living Experience Tanya–Louise's Story

Break & Reflect

20mins
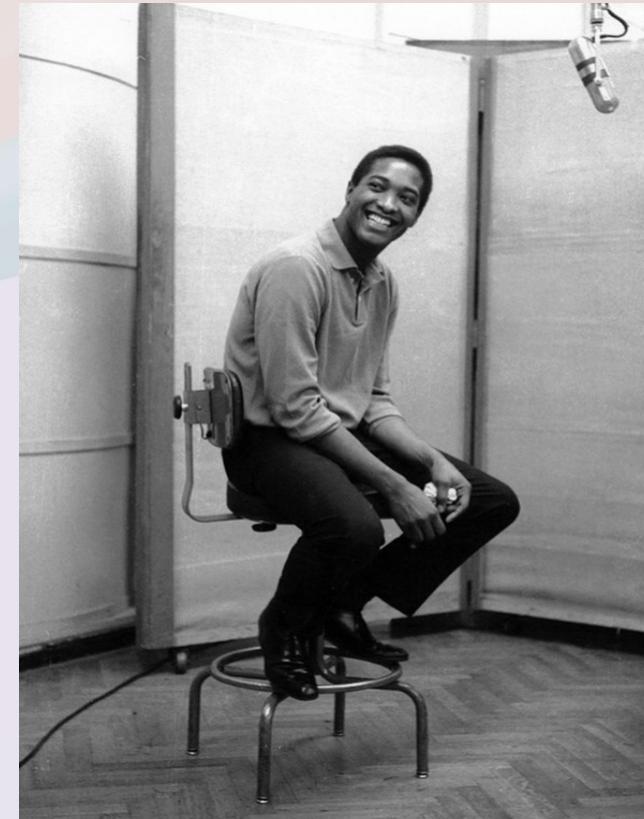
Sam Cooke - A Change Is Gonna Come (Official Lyric Video)

Side-by-Side Reflection: Case Study

Competencies →Action → Culture Change

Before we dive into the case study , let's build on our earlier reflection.

Think about the **perspectives, voices, or stories** you noticed were often missing in your own work or in the data we've just discussed.

- Who might be absent from this picture patients, staff, carers, or other stakeholders?
- What barriers – individual, team, or organisational might be keeping these voices from being heard or acted upon?
- How might the gaps you notice affect experience, outcomes, and equity?
- Keep these questions in mind as we examine the case study   your observations will help us translate data into dialogue and action, and think about how standards and competencies from PCREF can guide systemic change."

Willow Ward

'We don't see a problem'

Small inpatient ward with limited racial diversity among patients (around 5%).
PCREF leadership sits at senior levels but feels distant from ward life. Local data appears "in line" with national averages, so equity concerns are often dismissed.

Staff View:
"Our numbers look fine — we treat everyone the same."
Many staff are unsure how PCREF links to their day-to-day work, and few can name its priorities. Conversations about racism feel uncomfortable, especially in majority-white teams, so staff tend to avoid the topic.

Patient View:
Some minoritised patients describe subtle forms of exclusion — being stereotyped or not asked about cultural or family needs. When raised, these issues are often minimised as misunderstandings.

Data:
Slightly lower trust and communication scores among racialised patients. Because the sample is small, staff label these results as "statistically insignificant."

Equity, Equality & Harm Lens:
Inequity is hidden by small numbers and silence.
Equality is assumed rather than evidenced.
Harm occurs through avoidance — fear of "getting it wrong" leads to inaction.
PCREF feels like something done by leadership, not with staff.

Oak Ward

'We know but we are stuck'

Larger, more diverse ward (25% minoritised patients). Data mirrors national inequalities — lower trust, safety, and belonging scores for Black and Asian patients. Staff are aware but feel overwhelmed by where to start.

Staff View:
"We know inequity exists, but we don't have the tools or support to fix it."
Anti-racism feels abstract; cultural competence feels safer. Leadership is supportive in principle but unclear on how PCREF priorities connect to ward improvement plans.

Patient View:
Some patients feel unsafe raising racial concerns, fearing they won't be taken seriously. Others have seen microaggressions go unaddressed.

Systemic Context:
International staff report disillusionment over visa/sponsorship challenges and unequal career progression. Efforts to address racism often get lost in fragmented or competing action plans.

Equity, Equality & Harm Lens:
Inequity is visible but unresolved.
Equality efforts focus on compliance rather than co-production.
Harm continues through fatigue and disconnection.
Leadership intent isn't translating into lived experience improvement.

Reflective Group Exercise

Both wards represent different realities...
One **can't see** inequity, the other **can't act** on it.

Let's explore what's happening beneath the surface, and what that means for how we lead PCREF in practice.

Group Discussion (Willow & Oak)

Recognising the Challenge

1. What fears or assumptions might be holding staff back from discussing racism here?
2. How might leadership structure or communication be contributing to the lack of awareness?
3. What happens when PCREF feels like a senior management project rather than a shared responsibility?

Identifying the Harm

1. How does inaction — even with "good intentions" — cause harm to patients or staff?
2. What are the consequences of treating small data sets as insignificant?
3. What message does it send when racism or microaggressions are raised but not acted on?

Moving Toward Action

1. What would make anti-racism everyone's business rather than an add-on?
2. How could leadership share power or decision-making to build trust and visibility?
3. What would shift the culture from "cultural competence" (awareness) to "anti-racism" (accountability)?

How might wards use PCREF data as a learning and improvement tool, not just for reporting?

Whole Group Reflection

Patterns: What common challenges did you notice between Willow and Oak?

Leadership: How can senior staff model PCREF values in ways that feel relevant and inclusive to ward teams?

Courage: What supports do teams need to have brave conversations about racism safely and productively?

Action: What's one thing we could do differently tomorrow to make equity visible and actionable?

Accountability: How might we track and share progress so that learning doesn't fade into another "fragmented plan"?

Mapping to Culture of Care & PCREF

Challenge Theme		PCREF Application
Avoidance or discomfort discussing race	Compassion & Learning	Create reflective spaces for race dialogue and curiosity
Leadership distance from ward-level PCREF	Leadership & Team Voice	Co-lead equity work with lived experience and staff representatives
Data dismissed or fragmented	Safety & Improvement	Integrate PCREF metrics into QI cycles and supervision
Fatigue and disillusionment	Involvement	Align goals with visible staff and patient outcomes

2.1 Aligning The Two

Full details can be found in the Pre-Session Information Pack

Culture of Care Standard

Through a Racialised Lens — PCREF

1. Lived experience
We value lived experience

Lived Experience is valued at all levels

- Recruit & Pay Racially Diverse Peer Support Workers to Co-Lead ward activities and governance.
- Include lived experience representatives in care planning meetings, particularly for minoritised patients
- Co-run structured feedback sessions with minoritised patients and carers to inform ward processes

2. Safety
People feel safe and cared for

Patients feel safe & cared for

- Conduct Equity-focused safety audits to identify disproportionate use of containment of seclusion for minoritised patients.
- Review and implement racially aware de-escalation practice for all staff.
- Ensure staffing levels and skill mix reflect cultural and language needs of patients

3. Relationships
High-quality and trusting

High quality care starts with trust

- Create mentorship of buddy systems pairing minoritised patients with train peer advocates
- Establish structured opportunities for meaningful staff-patient dialogue focusing on culture, identify and needs
- Include family or community members, advocates / peer supporters in care planning where culturally appropriate

4. Staff Support
Present alongside distress

Staff are supposed to be supported present alongside people in distress

- Run reflective practice groups addressing anti-racism, racial bias and culturally informed care.
- Provide supervision that includes racial equity metrics and culturally appropriate strategies.

5. Equality
We are inclusive, value difference and promote equity

Inclusive and equitable access, treatment and outcomes

- Review referral, assessment and treatment pathways to identify racial inequities.
- Ensure care plans are adapted for neurodivergent & culturally diverse needs.
- Implement data monitoring by race / ethnicity to track equity in outcomes.

6. Avoiding Harm
Actively avoid harm and traumatisation

Racialised Lens...

- Audit incidents of restraint or rapid tranquilisation for disproportionate use against minoritised patients.
- Introduce trauma informed, culturally safe alternatives to coercive interventions.
- Document and reflect on harm caused by systemic bias in clinical governance meetings.

SLaM Anti-Racism Plan

- The Anti-racism Plan is a Trust-wide strategy that aims to embed anti-racism into each major operational arm of the Trust

- It is made up of up 5 workstreams

- The implementation of this plan is partly facilitated by the Anti-racism Developmental Evaluation Framework

- This framework helps to measure the workstreams' progress in developing their own Change Ideas and measuring them in terms of anti-racism impact

- So far, we can see there are different levels of progress for the different workstreams in setting up their Change Ideas and corresponding metrics

Governance and Workstream Progress

How we know:

- Insight comes through the Governance Framework
- Workstreams are expected to report progress to the Board

Current picture:

- Progress varies across workstreams
- Some have used co-production methods, others have not
- Some have identified metrics for success, others are still developing them

Challenges & Momentum in Embedding Anti-Racism

The challenge:
- Embedding anti-racism within organisations is complex and often uncomfortable
- Some participants in this programme may also be struggling with this process

In organisational contexts:
- Mental Health Trusts (e.g., SLaM) are not traditionally used to being responsible or accountable for anti-racism and racial equity
- As a result, collecting evidence from different workstreams within SLaM's Anti-Racism Plan has been challenging

The opportunity:
- For some workstreams, this challenge has become a catalyst for progress
- It has prompted greater transparency and momentum around metrics and evidence

Examples:
- Services (PCREF)
- Working with the Police

Services (PCREF)

Has seen the development of 3 Change Ideas and corresponding metrics through a co-development approach

Working with the Police

This workstream has seen the development of 3 Change Ideas and corresponding metrics through a co-development approach.

They also produced a framework for proposed governance at the Directorate Level

Black Thrive Global:
Building Race Equity into Systems Change

Programme Deliverables and Outputs

Delivered race equity training to the delivery team members (Delivery team support)
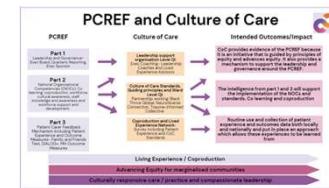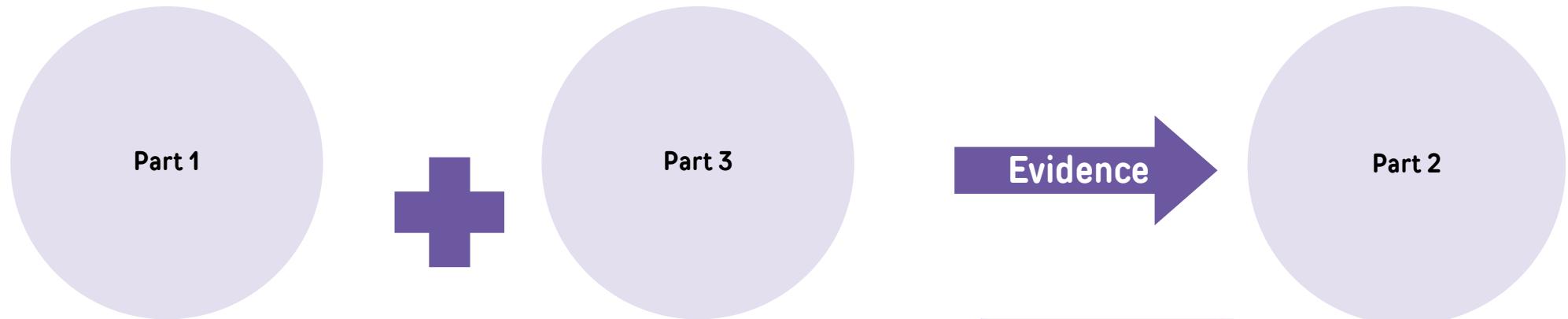
Supported QI sessions (ward level QI)

Attended ward visits

Race Equity Ward Reviews

Delivered executive coaching sessions (Leadership support)
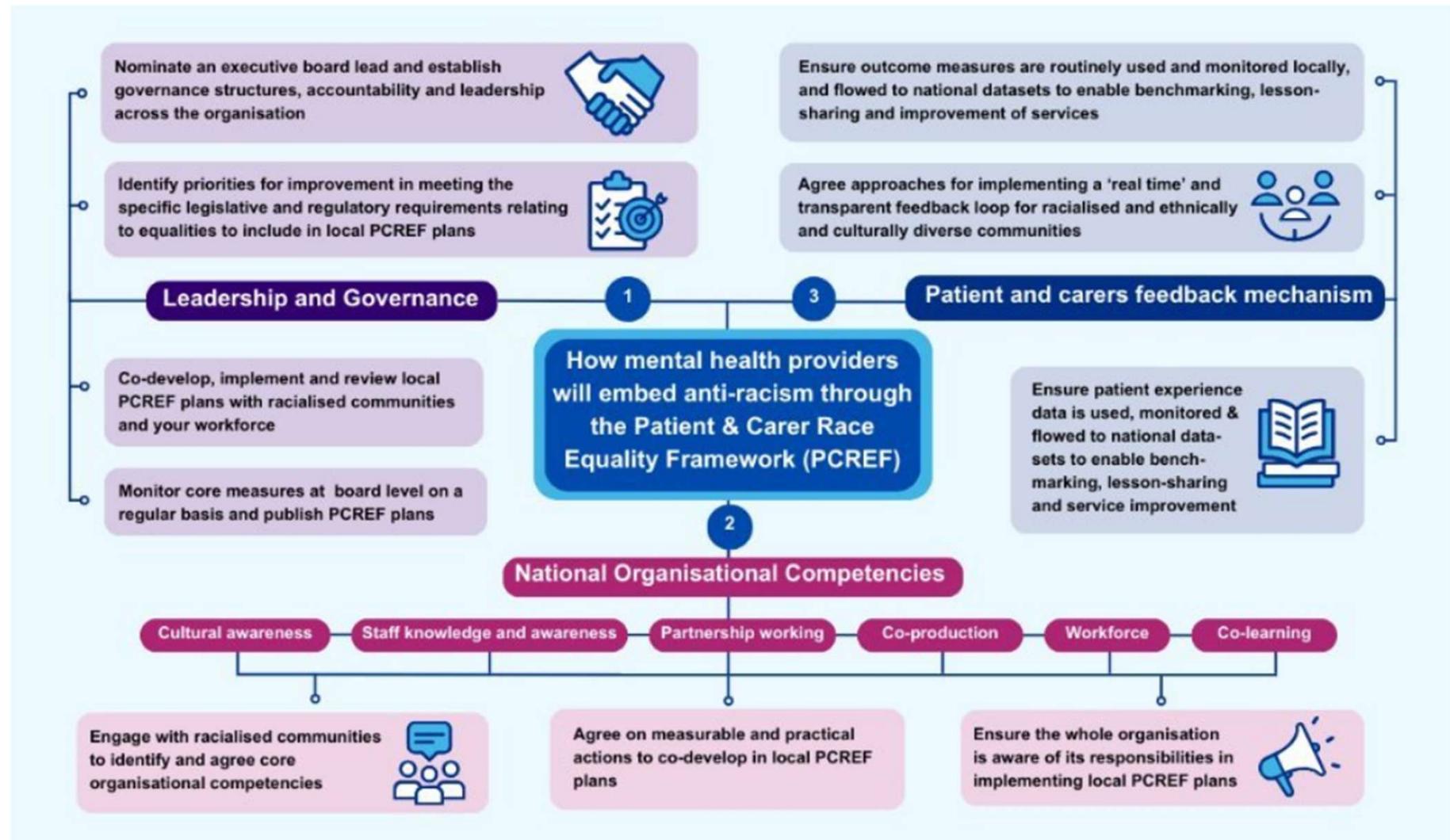
PCREF and The Culture of Care programme

Part 1

➕

Part 3

Evidence ➡

Part 2

Black Thrive Global's Programmes

Communities
Children, Young People & Families (CYPF)
Black Queer & Thriving
Thriving Futures

Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation

Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services

Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans

Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities

Leadership and Governance   1   3   **Patient and carers feedback mechanism**

How mental health providers will embed anti-racism through the Patient & Carer Race Equality Framework (PCREF)

Co-develop, implement and review local PCREF plans with racialised communities and your workforce

Ensure patient experience data is used, monitored & flowed to national data-sets to enable bench-marking, lesson-sharing and service improvement

Monitor core measures at board level on a regular basis and publish PCREF plans

2

National Organisational Competencies

Cultural awareness   Staff knowledge and awareness   Partnership working   Co-production   Workforce   Co-learning

Engage with racialised communities to identify and agree core organisational competencies

Agree on measurable and practical actions to co-develop in local PCREF plans

Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans

Questionnaire

Please scan the QR code to complete the questionnaire.
Your thoughts and feedback are very much valued

Link to form

Q&A and Closing