Response to: McMahon, W. and Roberts, R. (2008) *Ethnicity, harm and crime: a discussion paper*

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October 2008

Introduction

The dominant and accepted approach to understanding the situation of ethnic minority people in the UK conveniently sees such groups as the cause of their own problems and, more generally, as disruptive to the stability of our society. This discussion paper represents an important corrective intervention in such debates and for this the authors and the Centre for Crime and Justice Studies should be congratulated. Below I highlight what I consider to be the key points of the document, add to them, and offer some suggestions for further consideration.

The three key points that emerge in the document are that:

1. 'Black on Black' crime and the policy focus on it need to be understood within the context of the wider, and much more significant, social harms experienced by Black people.
2. 'Black on Black' crime, and the greater representation of Black people as both perpetrators and victims of crime, can only be understood as a consequence of wider social inequalities, where ethnic minority groups experience (on average) greater economic hardship, discriminatory attitudes, and racist attacks (written, verbal and physical).
3. Consequently, a narrow focus on 'Black pathology' (for example Black street culture, the Black family, or gang culture) misses the fundamental causes of the problems faced by ethnic minority people and acts to further racialise Black people.

State inflicted social harm, how significant is this?

Adopting a social harm perspective, the report sets out to highlight the risks that society and the state create for young Black men and the significant harm that results. The emphasis is rightly on the role of the state and state institutions. Two outcomes are worth emphasising and detailing further. First, most studies of admissions to psychiatric hospitals suggest that Black Caribbean people are between three and five times more likely to be admitted with a serious mental illness (McGovern and Cope 1987, Harrison *et al*. 1988, Cochrane and Bal 1989, Van Os *et al*. 1996). These rates are even higher for young men, and extraordinarily high for young Caribbean men who were born in the UK – one study suggests 18 times higher than average (Harrison *et al*. 1988, see also McGovern and Cope 1987). Findings from these studies cannot be understood in terms of a genetic, or cultural, risk associated with a general Caribbean identity, because rates of severe mental illness in the Caribbean are pretty average (Hickling 1991, Hickling and Rodgers-Johnson 1995, Bhugra *et al*. 1996). So, insofar as they represent real differences in risk, these high rates of hospital admission must reflect the negative impact of the UK social context on Caribbean people, particularly young men. And if the size of this difference is real, this negative impact surely requires immediate and serious consideration. We would also hope that once such harm has been inflicted, those most affected would receive high standards of care, but, as Professor Dinesh Bhugra, the

President of the Royal College of Psychiatrists has commented (Observer 2008, Bhugra 2008), this expectation is not fulfilled. It would not be unfair, despite the claims of some (Singh and Burns 2006), to suggest that mental health services aggravate, if anything, any pre-existing harm experienced by such patients (Fernando 2003).

The second example I consider here is the high rate of imprisonment faced by young Black men, and the long-term consequences for those who are imprisoned. This mirrors young Black men's increased rates for admission to hospital with a severe mental disorder. And there are great similarities in the pathways taken by young Black men into hospital and prison, which in both cases are adverse compared with others. So, as described in this report, in the criminal justice system young Black men are more likely to be stopped and searched, within a given context they appear to be more likely to be arrested, are less likely to be cautioned, more likely to be convicted and likely to receive a longer sentence. And in the mental health system, Black people are more likely than others to have been in contact with the police or forensic services prior to admission, are more likely to have been referred to these services by a stranger rather than by a relative or neighbour, are over-represented among patients compulsorily detained in psychiatric hospital, and this is despite studies in the UK showing the Black Caribbean patients are both less likely than white patients to display evidence of self-harm and no more likely to be aggressive to others prior to admission (Harrison *et al*. 1989, Rogers 1990, McKenzie *et al*. 1995, Davies *et al*. 1996, Audini and Lelliot 2002, Morgan *et al*. 2005a and 2005b, Sainsbury Centre for Mental Health 2006). Similarly, Black Caribbean patients with a diagnosis of psychosis remain in acute hospital care longer than white patients and have more frequent outpatient follow-up contacts, despite having fewer negative symptoms (Takei *et al*. 1998, Commander et al 2003). These differences in pathways into prison and psychiatric care suggest that young Black men may well be overrepresented in such institutions. So, it is perhaps not surprising that community based surveys of criminal activity and mental health, in contrast to studies of contacts with institutions, suggest that Black people are not more likely than white people to be involved in criminal activity or to have a serious mental illness. For example, the Offending Crime and Justice Survey shows that white people are 50% more likely than Black people to report that they have committed both an offence and a serious offence, are 20% more likely to report that they have engaged in anti-social behaviour, or to have taken an illegal drug, and twice as likely to report that they have taken a class A drug (Sharp and Budd 2005). For serious mental illness the contrast is equally stark. Compared with the three to five times greater risk of hospital admission, community surveys have suggested that the prevalence of psychotic symptoms is about twice as high for Black compared with white people (King *et al*. 2005) and that serious psychotic illness is about 75 per cent higher (Nazroo 1997). And this higher rate is not found for young men, nor for young men born in the UK.

This is not to suggest that Black people in prison have not committed crimes, nor that Black people in psychiatric hospitals do not have severe mental illnesses, even if in some circumstances this may be the case. Rather, this evidence suggests that Black people are more likely to experience adverse pathways into such institutions, are consequently more likely to be present in these institutions, and that the impact of this is to aggravate substantially any pre-existing inequality. The implication is that state institutions are not concerned to address the social inequalities that might underpin any increased risk of criminal activity or severe mental disorder, rather they manage the situation in a way that amplifies race/ethnic inequality.

How do we explain such inequalities?

Before we consider explanations for these social inequalities and why they might be aggravated by state institutions, it is worth considering what we mean by ethnicity, or race, in this context. Here I draw heavily on the work of Solomos (1998) who argues (I paraphrase here) that ethnic or race groups are discursive formations, calling into being a language through which apparent biological and cultural differences are accorded social significance, and by which these groups are named and explained. So the relative social location of ethnic groups is understood to be a consequence of biological and cultural differences, and such differences are generalised across all of those who are seen to be members the group. The names and explanations are reified, generalised and personalised. But then we need to understand why ethnic relations take the form they do. How do the categories and the boundaries between them come to be? And how are the meanings attached to these categories and the boundaries between them negotiated and resisted? Of course we can only understand this in relation to broad historically embedded social processes. I do not have the space to document these here, but it is worth asking why the contemporary consequences of these processes are not addressed more forcefully – who benefits from the status quo? To answer this we need to engage with an analysis of class as well as ethnicity/race, and for this analysis of class to be more than just a description of socioeconomic inequalities. We need to develop an understanding of how ethnic/race relations relate to, are configured by, and support class relations. And this requires an exploration of class inequalities more generally, the mechanisms that produce and maintain them, and their 'side effects'. For example, how has our society become one where 1.4 people per thousand is in prison – who benefits and why?

Rather than look more closely at such issues, this discussion paper makes use of the concept of an 'ethnic penalty' to explain social inequalities. This simply asserts that in a particular context some ethnic minority groups do worse on average than others. It is, in effect, a statistical description, assessing the size of an average difference compared with equivalent, or similarly placed, white people (the difficulty of estimating equivalence when circumstances can be radically different is rarely considered within the statistical models that are typically used to measure the extent of ethnic penalty). Such a statistical description, even when it is accurate, does not contain an explanation for the gap described as an ethnic penalty. We are left to hypothesise what the explanation is – racism (as suggested by the paper's authors), culture, or biology? The health literature is replete with examples of a resort to biological or cultural explanations in such circumstances. Importantly, an approach such as this simply statistically controls for observed socioeconomic differences, it fails to explain the relationship between ethnicity and social position. And it fails to engage with an analysis of the wider processes generating social and economic inequality and how ethnicity/race intersects with these. Answering these questions is not a straightforward process, nor uncontroversial, but our understanding cannot develop unless we are prepared to engage in this hard task.

What are the implications for policy?

Perhaps the important weakness of this report is its failure to spell out implications for policy. Although not explicitly stated, it is clear that the authors identify social inequality and the racialisation of that inequality as the fundamental driving mechanism of the social harm they describe. Such problems are resistant to serious, rather than pop, policy analysis, making it extremely difficult to develop recommendations for policy intervention that are both effective

and acceptable. Take the example of inequalities in health. Both of the Government inquiries into these (Townsend and Davidson 1982, Independent Inquiry into Inequalities in Health 1998), and numerous other investigations, have identified socioeconomic inequalities as the driver of health inequalities. But we have seen repeated failures over the past ten or so years for any serious policy development to address socioeconomic inequalities. The reasons for this are, perhaps, obvious, but also relate to a desire to have simple analyses of and simple solutions for complex social problems, of which the ways in which young Black men have been racialised in this country are an example.

So the challenge I offer – to develop serious and effective policy recommendations to complement this analysis – is nowhere near straightforward. But the momentum is there for this next step. The significance of the social harm experienced by these young men – the gross economic inequalities, restrictions to social mobility, removal of liberty, consequent illness and premature mortality and ultimately, in contemporary Government speak, the impact on well-being – is simply unacceptable. This discussion paper illustrates this with remarkable clarity.

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