

BHA for equality – Black History Month

More Than a Month.

Confronting the Health Inequalities Facing Black People

Black History Month is often framed as a celebration – and it should be. It's a chance to celebrate culture, achievement, and the contributions Black communities have made, and continue to make, to this country. But held alongside that celebration should be an honest look at what hasn't changed. Because for all the awareness campaigns, all the conversations, all the messages of solidarity every October, Black people in the UK are still measurably more likely to be detained under the Mental Health Act, more likely to die of prostate cancer, more likely to wait years for a gynaecological diagnosis, and more likely to die during childbirth.

None of this is new information. Much of it has been documented, reported and raised, formally, by the people affected, for years. This piece is about four of those realities, and about a question that sits underneath all of them: if the evidence has been there all along, why hasn't more changed?

Detained, not supported

Black people in England have been detained under the Mental Health Act at between three-and-a-half and nearly five times the rate of White people in every year on record since at least 2019/20, most recently 262.4 detentions per 100,000 people for Black people compared with 65.8 for White people in 2024/25, nearly four times the rate (NHS England, September 2025). Black African and Caribbean men are three to five times more likely to be diagnosed with psychosis than their White counterparts. And the route into that diagnosis is rarely a straightforward one: across 40 UK studies, Black African and Caribbean people were around three times more likely than comparison groups to have the police, rather than a GP, involved in their pathway into care. This is not simply a story about illness, and it is not one that has improved with time, it is a story about a system that has met Black men, in particular, with policing rather than support, for five consecutive years of published data.



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This doesn't start in adulthood. Half of all mental health problems are established by age 14, and three-quarters by age 24 (Kessler et al, 2005). Meaning what happens to Black boys in childhood and adolescence matters enormously to what happens to Black men later. And what happens, often is racism, encountered early: a US child and adolescent psychiatrist, writing in 2023, described treating a kindergartener left sad and withdrawn for weeks after White classmates told them their skin was "too dark" to play with them, and a fourth grader who said they wanted to die after white neighbours called their skin "ugly", cases she said too few of the other clinicians involved thought to connect to racism at all (Calhoun, 2023).

This isn't confined to history, or to adults. The most recent NHS data on children's mental health services (2023-24), published by the Children's Commissioner for England in May 2025, using NHS treatment records; shows Black children made up just 4% of children accessing NHS mental health treatment, against 6% of the child population, but 29% of referrals for Black children were crisis referrals, the highest proportion of any ethnic group, rising to over a third among those who went on to receive treatment. Even now, the system is more likely to meet a Black child once they are already in crisis than to have reached them before it got that far. Tellingly, NHS Digital's own flagship survey of children and young people's mental health doesn't currently publish a breakdown by ethnicity at all, so even the basic question of how prevalence compares for Black children isn't one of the published data can answer. Racism, in other words, is rarely asked about, or recorded, in a clinical mental health assessment, and a child can carry that weight for years before a service ever names it.

This isn't unknown to the people responsible for fixing it. The 2018 Independent Review of the Mental Health Act was launched partly because of exactly this pattern, and it recommended culturally appropriate advocacy as part of the fix. In 2022, a parliamentary committee went further, recommending this become a legal right. In 2024, the Government said no to making it statutory. When the new Mental Health Act finally passed in December 2025, that still wasn't in it. Campaigners called it a missed opportunity. It's hard to disagree — this wasn't a case of the problem being hidden or the solution being unclear. Both were put in front of decision-makers in detail, and the decision was made anyway not to act on them.

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**Black Health Inequalities in the UK:
The Data, The Stories, The Solutions**



A risk we don't talk about enough

One in four Black men in the UK will be diagnosed with prostate cancer in their lifetime — roughly double the risk faced by men overall. They're diagnosed younger, on average five and a half years earlier than White men, and they're dying at higher rates too: Black Caribbean men have a mortality rate 1.73 times that of White British men. Genetics plays a part, but researchers are clear that biology alone doesn't explain a gap this wide.

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What does help explain it is a system where the responsibility to ask for a PSA test still sits with the individual man, not with a service that already knows he's at higher risk. Where trust in healthcare, shaped by real history, is lower. Where men report being treated differently, their concern misread as aggression rather than fear. There are good initiatives responding to this – earlier PSA conversations from age 45, trials specifically recruiting Black men, community outreach like the Man Van. But it's worth asking why interventions like this are still framed as pilots, years after the risk has been known, rather than as the default way services are designed.

Waiting, and not being believed

Black women with fibroids wait longer for treatment – over half wait more than two years for a diagnosis, and a quarter live with fibroids for over a decade before receiving care. Black women are around 50% less likely to be diagnosed with endometriosis than White women. Black Caribbean and Black African women are more likely to be diagnosed with ovarian and uterine cancer at a late stage. And in a recent survey of primary care experiences, 49% of Black respondents reported being treated differently because of their ethnicity, including having pain dismissed or minimised.

What's striking here isn't only the outcomes – it's how much of the evidence base is still missing. Endometriosis UK's own diagnosis survey had so few Black respondents that the charity says it can't draw reliable conclusions from its own data, and has had to launch a new survey just to start filling that gap. When an entire condition's evidence base doesn't reliably include Black women, that is itself part of the inequality, not separate from it.

Where the “strong Black woman” myth comes from

The idea that Black women are “strong” and need less pain relief is not a modern misunderstanding – it has a documented history in medicine itself. In the 1840s, the American physician J. Marion Sims developed the surgical technique for repairing vesicovaginal fistula by operating repeatedly on enslaved women in Alabama, without anesthesia, Anarcha, on whom the technique was finally successful, underwent at least 29 operations. As enslaved women, none of them could meaningfully consent. Medical writing from that era, and for decades after, recorded the belief that Black people felt little or no pain during invasive procedures, a belief later found still in print in the early twentieth century.



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That history hasn't stayed in the past. A 2016 US study found that half of a sample of white medical students and residents endorsed at least one false biological belief about Black people, such as that their skin is thicker or their nerve endings less sensitive – and that holding these beliefs was linked to recommending less accurate pain treatment for Black patients (Hoffman et al., 2016). There's no evidence anyone is taught these specific claims as fact today. But some claims stayed in official clinical tools for far longer than they should have. In the UK, a formula used to estimate kidney function assumed Black patients had higher muscle mass and adjusted their results accordingly, without ever being validated in a UK population. It was only removed from NICE guidance in August 2021.

And the effect on pain relief in childbirth today is not just historical. A national study of 2.7 million births in England found Black Caribbean women were 8% less likely to receive an epidural during vaginal birth than White women, and 58% more likely to need general anaesthesia – a higher-risk option – for a planned caesarean (Bamber et al., 2023). Five X More's 2025 survey found 23% of Black women who asked for pain relief in labor did not receive it, often referred to as "white". While I didn't need anything stronger than paracetamol, meanwhile a non-Black patient in the same bay was given gas and air immediately." Birthrights' 2022 inquiry documented the same pattern directly, including a case where a woman's pain was dismissed by staff who assumed she was "either strong enough or exaggerating."



Still more likely to die

Black women in the UK are more than twice as likely to die during pregnancy or shortly after birth than White women. Black babies are more than twice as likely to be stillborn. These figures have improved slightly from the "five times more likely" statistic that gave the Five X More campaign its name in 2019. But the Health and Social Care Committee itself has cautioned that this narrowing partly reflects outcomes worsening for other groups, not real progress for Black women. Meanwhile, around £95 million of funding that had been ring-fenced for maternity safety was not restored, despite repeated calls to do so.

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The same story, four times over

Look across all four of these areas and a pattern repeats. All of it has been raised, formally and repeatedly, by the people living it, by researchers, and by official reviews commissioned by government itself. And in each case, the institutions with the power to act have had the chance to, and chosen a slower, softer response instead – a pilot instead of a right, guidance instead of legislation, a review instead of funding.

This is also why Black History Month itself deserves a harder look. It's not the fault of the people organising events, writing fact sheets, or having these conversations in good faith. But there is a real risk that institutions treat the month itself as the response – a few weeks of awareness, a few statistics shared, a moment of reflection – without any of it translating into what actually changes for the rest of the year.

Raising awareness is not the same as taking action. And the institutions being asked to change are not the same as the people asking them to.

What we're holding onto

None of this is a reason for despair. Every statistic in this piece exists because someone; a researcher, a charity, a campaigner, often a Black woman or a Black man who had lived through it, insisted on counting it, naming it, and refusing to let it go unrecorded. That work is itself a form of hope: the evidence is not missing, the case has been made, and the people affected have not stopped asking. What's still missing is the response to match it.

So, the honest question for this Black History Month isn't just what does this month mean to you – it's what changes because of it. That's a question for BHA as much as for anyone else, and it's one we intend to keep asking, out loud, past the end of October.

Health equity is racial justice.

Change starts with truth. Action sustains change.

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