



The Bradley Commission

1 Black and Minority Ethnic communities, mental health and criminal justice

Introduction

In 2009, the *Bradley Report on people with mental health problems or learning disabilities in the criminal justice system* was published. Four years on, Lord Bradley is chairing an independent commission, made up of leading figures from the fields of politics, criminal justice, policing, social care and health, to review progress and consider how the report can be implemented in the very different financial and policy environment we now face. The commission has asked Centre for Mental Health to report on areas that were under-developed in the Bradley Report, beginning with the needs of Black and Minority Ethnic (BME) communities.

This report is an appraisal of best practice provision of those services working with BME communities

at critical points of the criminal justice pathway (see Centre for Mental Health, 2009). By examining the specific needs for mental health and learning disability support among BME communities in the criminal justice system (CJS), we will be better placed to understand how the Bradley Report's recommendations can work for diverse communities.

In this report the term BME comprises all groups other than 'White British'. We recognise that BME communities are not a homogenous group and that individual circumstances and needs are complex and varied. As in the Bradley Report, the term learning disabilities includes both learning disabilities and learning difficulties.



Background

BME communities are disproportionately represented both in mental health care and in the CJS. People from BME communities are more likely to be diagnosed with a serious mental illness, such as schizophrenia, than their White counterparts and prescribed higher doses of medication. Although some BME communities are treated more frequently for psychosis, it is disputed that they are disproportionately more likely to have such an illness (Nazroo & King, 2002). Accordingly, some communities, most notably Black Caribbean and Black African, are more likely to experience admission under the Mental Health Act 1983 and are over-represented in psychiatric and secure mental health hospitals (Rutherford & Duggan, 2007; Commission for Healthcare Audit and Inspection, 2005). Within the learning disability provider inpatient population for England, particularly high admission rates were reported for Mixed White/Black Caribbean, Black Caribbean and Other Black ethnic groups and particularly low rates were reported for White Other, Asian and Chinese ethnic groups (Emerson & Hatton, 2008).

The majority of BME communities are disproportionately over-represented at all stages of the CJ process, as summarised in Table 1. BME communities make up about 25% of the UK prison population (Ministry of Justice, 2012a), compared to 11% of the general population (Ministry of Justice, 2011a). Strikingly, Black Britons make up 10% of the UK national prison population (Ministry of Justice, 2012b), a figure three times greater than their proportion in the general population (ONS, 2011). 20-30% of offenders have learning disabilities that interfere with their ability to cope with the CJS but precise information about prevalence among BME groups is virtually non-existent (Loucks, 2007). It is estimated that 2% of the general population in England have a learning disability (Emerson & Hatton, 2008), and it is highly likely that people from BME communities with learning disabilities are disproportionately over-represented in the CJS.

Perversely, despite over-representation both in mental health care and in the CJS (Table 1), there is evidence to suggest that Black and other BME prisoners are under-represented in

Table 1: Proportion of individuals at different stages of the CJS by ethnic group compared to general population for 2009, England and Wales

	White (%)	Black (%)	Asian (%)	Mixed (%)	Chinese or other (%)	Unknown (%)	Total
Population aged 10 or over in 2009	88.6	2.7	5.6	1.4	1.6	-	48,417,349
Stop and Search (s1) 2009/10	67.2	14.6	9.6	3.0	1.2	4.4	1,141,839
Arrests 2009/10	79.6	8.0	5.6	2.9	1.5	2.4	1,386,030
Cautions 2010 *	83.1	7.1	5.2	-	1.85	2.8	230,109
Court order supervisions 2010	81.8	6.0	4.9	2.8	1.3	3.2	161,687
Prison population (including foreign nationals) 2010	72.0	13.7	7.1	3.5	1.4	2.2	85,002

* These data are based on ethnic appearance and therefore do not include the Mixed category.

Source: Ministry of Justice, 2011a

prison mental health team caseloads (Centre for Mental Health, 2011a) and within services that may prove beneficial, such as drug court initiatives (Bradley, 2009) and Improving Access to Psychological Therapies (IAPT) programmes.

Inequalities

BME communities experience a range of inequalities which can put them at greater risk of mental health problems and encounters with the CJS.

Many BME communities occupy particular positions of disadvantage in the UK. They experience inequalities across all indicators of economic and social wellbeing. They generally have higher rates of unemployment, live in poorer housing, report poorer health, and have lower levels of academic achievement (Keating, 2007).

Female BME offenders, in particular, represent multiple marginalised identities (Mereish, 2012). Not only are BME women over-represented in the CJS with regard to their ethnicity but there is also a higher proportion of BME women in prisons when compared to men of the same heritage (Keating *et al.* 2003). By the same token, 78% of women entering prison exhibit some level of psychological disturbance compared to 15% of the general female adult population (Plugge *et al.* 2006).

Predominantly, the histories and subsequent offending behaviour of BME women have roots in gender inequality, which might include sexual violence, trafficking, prostitution and female genital mutilation. Despite representing just 5% of the total prison population, women account for 31% of all incidents of self-harm (Ministry of Justice, 2011b) and research indicates that rates of suicide and self-harm are higher than average among certain groups of Asian women and young African-Caribbean and Irish people (Keating *et al.* 2003).

Institutional racism

Historically, institutional racism has contributed to disparities in access to health care. Even dress code and accents, rather than the inability to speak English, have been noted as identifiers of vulnerability to discrimination (Weerasinghe, 2012; Holland & Ousey, 2011). In a bid to address institutional racism some services inadvertently exacerbated the problem by positioning themselves as ‘colour blind’ or a ‘one size fits all’ service. This has now been recognised as culturally insensitive and ineffective but there is still some way to go.

Lack of awareness and trust

Some BME communities are less able to identify poor mental health or perhaps western concepts of ill health, which can contribute to a lack of awareness of sources of help (Keating, 2009). Cultural pressures and ideology impact on some BME and religious groups’ access to healthcare (Weerasinghe, 2012), for example the imperative to ‘save face’ and maintain social status and moral reputation (Mereish, 2012). Fear of stigma can also be a barrier and there may be the feeling that care is a family responsibility (Cooper *et al.* 2012).

Negative perceptions of mental health services can stem from perceived racism, language barriers and doubts about the cultural competency of services (Cooper *et al.* 2012). Alarmingly, ‘a real and potent fear exists’ within some African-Caribbean communities ‘that involvement with mental health services could eventually lead to their death’ (Keating & Robertson, 2004). All of these factors can result in a delay in seeking help with the consequence that some BME communities only access services at crisis point and are reluctant to engage (Keating *et al.* 2003).

Coercive pathways

In conclusion, BME communities are 40% more likely than White Britons to access mental health services via a CJS gateway (Bradley, 2009). Black people, in particular, are more likely to experience higher compulsory admission rates to hospital, greater involvement in legal and forensic settings and higher rates of transfer to medium and high security facilities, prompting the government to concede that there remains an undue emphasis on coercive models of treatment for Black mental health service users, where professional and organisational requirements may be given priority over individual needs and rights (Department of Health, 2003). Thus, the interface between mental health care and the CJS is of crucial importance, whereby diversion necessarily takes on a greater significance and urgency, and perhaps a slightly different dynamic, when it comes to provision of services for BME groups.

Review methods and findings

Despite all of the issues touched upon above there remains a lack of evaluative research and policy initiatives which show what works for these client groups. This report seeks to re-open the debate and call attention to some of the core components of services we identified as engaging effectively and working well with BME communities in a liaison and diversion capacity. In doing so, contributions from a large number of individuals and organisations were gathered through a range of methods. This included individual meetings and semi-structured interviews with heads of agencies, organisations and professional groups; a focus group with service users and mentors, and visits to twelve initiatives across the country (listed below).

Liaison and diversion schemes typically operate where criminal justice and mental health services meet. However, in the absence of services catering specifically for the needs

of those from BME communities at key points along the pathway, a more inclusive approach was adopted for the purposes of defining liaison and diversion in this context. This was to ensure that all interventions from the various agencies involved both inside and outside the CJS pathway that have the potential to address mental health and reduce offending were considered. Within this frame of reference it was the ‘community’ that tended to offer up many of the good practice examples of working with BME communities in respect of liaison and diversion, albeit perhaps in its broadest sense.

The clients that were seen by community-based organisations were predominantly male, with mental health or learning disability needs and invariably a multiplicity of socio-economic needs. We visited one gender-specific service which saw women coming before the courts. 60% of these clients were said (anecdotally) to be from BME backgrounds.

Services visited

We would like to thank the services we visited for their help and cooperation:

- African and Caribbean Mental Health Services, Manchester
- African Caribbean Community Initiative, Wolverhampton
- Elmore Community Services, Oxford
- HMP/YOI Peterborough In-Reach Team
- Nafsiyat Intercultural Therapy Centre, London
- Pakistani Resource Centre, Manchester
- Penrose Fusion, London
- PLIAS Resettlement, London
- Sheffield African Caribbean Mental Health Association
- St Giles Trust, London
- Together, London
- Wai Yin Chinese Women’s Society, Manchester

Diversion in the community

It is widely recognised that a significant proportion of those in the CJS harbour poorly recognised and inadequately managed complex needs, including mental health problems and learning disabilities (Centre for Mental Health, 2011b). It is estimated that 70% of prisoners have two or more mental health disorders (Singleton *et al.* 1998) and that 20-30% of offenders have learning disabilities that interfere with their ability to cope with the CJS (Loucks, 2007). Thus, a primary task of liaison and diversion is to identify, screen and where appropriate assess support needs, in particular, mental health and learning disability, and to facilitate early intervention and alternatives to incarceration.

There is a particularly strong case for diverting offenders away from short custodial sentences towards effective treatment and support in the community. Ideally, successful intervention will result in the provision of mental health care or support from learning disability services. It will also engage services in the community catering for a range of needs, such as supported housing, benefits advice and routes to employment. In addition to improvements in mental health and wellbeing, well-designed arrangements have the potential to yield multiple benefits, such as a reduction in health inequalities and social exclusion, improvements in public protection, reductions in re-offending, and cost and efficiency savings within the CJS.

A range of activities is carried out by third sector community-based organisations, which aim to deflect their BME clients from the CJS and ensure they receive appropriate care. Although rarely termed liaison or diversion, their work often involves both and they can be an important part of the pathway, offering resources and expertise. For example, the African Caribbean Community Initiative (ACCI) in Wolverhampton provides pre-arrest, preventive services, such as early identification of risk factors for vulnerability, mental health problems, learning disabilities and offending. They are supportive of protective factors and

are able to identify their vulnerable clients before they experience crisis. ACCI have also forged good links with mental health and other support services and work with families and carers to offer on-going support.

“We have a relationship with them, not just when they’re unwell but also when they’re well, so we share the good times, so that when the bad times come we’re ready.”
(ACCI staff member)

Point of arrest

The point of arrest is a vital moment in the criminal justice pathway, where sound practical decisions can change the course of an individual’s interaction with the CJS. It is essential that statutory and community agencies work in partnership and forge a network across which knowledge can be shared. All of the services identified in this report had contacts with several other community organisations and statutory agencies.

The Mental Health Caseworker at the African and Caribbean Mental Health Services (ACMHS) in Manchester had good links with the local police and this had led to him being consulted at the point of arrest and custody suite stages. He said:

“I’ve got a caseload of forty-odd and three quarters of them are criminal justice clients. There is a lot of misunderstanding of how they express themselves, and yes, there have been instances of wrongful detention. But the police will call me if they think I can help and we always go and assist. It can lead to discontinuance. If I know the person I can inform them about the mental health perspective. There was one example of a woman who would have had her kids taken into care had she not got bail. Luckily we managed to avoid that.”
(ACMHS staff member)

Where practitioners lack a particular cultural expertise they need to be able to effectively partner relevant culturally-specific agencies. The community-based agencies that we met worked together to ensure that sections of the community were not left without a service. For example, ACMHS had forged a partnership with the Wai Yin Chinese Women's Society in Manchester and had strong ties with the local Pakistani Resource Centre, all of which work with criminal justice agencies.

Support between the arrest and court stage

The Fusion Project run by Penrose in London is a good example of a third sector agency linking in strategically at this point on the pathway. They run a liaison and diversion pilot funded by the Department of Health and Ministry of Justice as part of an alternative to custody project and employ a mental health nurse to work mainly (but not solely) at the pre-sentence stage. At the most recent count, 72% of service users were from BME communities.

The mental health nurse:

- receives referrals from Penrose Fusion (PF) and probation staff of offenders with low-level or undiagnosed mental health issues or learning disabilities;
- conducts mental health and learning disability assessments to help identify support needs and signposts service users to appropriate services;
- provides advice on mental health issues, for eligible service users, to Penrose Fusion and CJS staff;
- actively contributes to reports requested/required by Magistrates prior to sentencing or bail applications;
- encourages service users to utilise PF activities and programmes reflective of their assessed needs;
- encourages the use of the peer support volunteers to reduce social isolation.

Although assessments conducted by the nurse will not result in a definitive diagnosis under the Mental Health Act, they provide an indication of how the service user can be supported into or

sustained in treatment. They assist the service user to recognise their mental health needs, and can contribute to pre-sentence reports by suggesting how support needs can be met by the project and other agencies. The nurse is also available to accompany offender managers to home visits where necessary.

All service users who are referred and accepted into the service are required to attend PF workshops and are encouraged to become a support volunteer. This is achieved by including these actions into sentence plans.

Fusion service users were asked what it was that made the project a viable option for them. Responses included:

- the dedication of the staff
- the fact that service users are paid travel expenses whether visiting for an appointment, group-work or to see the nurse
- there is a voucher scheme whereby service users receive a £10 voucher for every three workshop sessions they attend.

Staff also said that location was crucial to their successful running. The Fusion office is in a central Lewisham location with both the police station and the probation office very close by. Over the last twelve months only 7% of service users had reoffended, compared to 26.9% for England and Wales in 2010/11 (Ministry of Justice, 2013), and 3.2% of service users had relapsed/re-entered hospital.

Court stage, sentencing and probation

Historically, liaison and diversion schemes have been predominantly court-based and their development patchy. Where they did exist, they worked to different models and configurations from a range of providers including the voluntary sector. Research has also revealed that very few schemes had any learning disability expertise (Nacro, 2006). The evidence suggests that due to this piecemeal development, BME communities have not been served well by court-based schemes. On all the key measures, such as screening, assessments,

liaison and partnership, recording and monitoring, BME groups were not receiving parity with White counterparts or an equitable service (Nacro, 2007).

We sought to identify which initiatives were exhibiting some measure of best practice. Elmore Community Services was one such project. It runs a court liaison pilot service in Oxford and provides targeted and assertive support for marginalised and disenfranchised people with complex needs. Core services include advocacy, advice and information, coordination and connection, emotional support, outreach and practical help, such as assisting clients to attend appointments. The service is characterised by its flexibility and holistic nature as well as its ability to work with high risk clients:

“We work with people that other agencies really don’t want or have given up on, people with 3 to 5 support needs at any one time, high risk clients in the community. But we do have really strong risk assessment and management. We have really strong boundaries but work really creatively with individuals.”

(Elmore Staff member)

The court liaison practitioner visits the court two days a week. The practitioner’s main role is to refer clients to services that can provide on-going support in the community:

“If they’re likely to be released I’ll organise support in the community for when they step out of the courtroom, so they have a plan, a follow up... but if they’re likely to be detained I’ll liaise with the prison, talk to the mental health team, pick up on any risk information, keep track of people and make phone calls before they’re due to be released.”

(Elmore staff member)

Despite not being a BME-specific service, Elmore is a good example of a team which, through a well-developed person-centred approach, appears to serve all its clients well. Elmore crucially has a positive and proactive approach to collaborative working which can be an effective way of non-specialist liaison

and diversion schemes meeting the needs of BME service users. The Elmore ethos extends to staff make-up or mix, which although based on skills and abilities, is also representative of the community. Elmore employs a range of initiatives that appear to work well for BME clients. They also provide ample opportunity for clients to volunteer and to be involved in the service. Service users meet with board members on a quarterly basis, give feedback on aspects of the service, are involved in delivering workshops and tendering activities and are generally given the opportunities to acquire skills and grow their own knowledge base. With a robust safeguarding policy volunteers can be set up with placement opportunities with outside agencies and projects.

Discussions with sentencers in Oxford established that they valued the work that the Elmore court liaison pilot carries out. Magistrates exhibited the usual frustrations of sentencers who generally have limited mental health and learning disability options at their disposal and of a population coming through the courts of which they estimate 50% have ‘personality problems’. The Elmore practitioner working with probation had made a difference, they said. The issue of training was raised and it was noted that magistrates would have liked more mental health training, although they did not believe that this would affect the limited options that were available to them. The one option that was mentioned was the Mental Health Treatment Requirement (an option when giving a Community Order sentence) but even this was bemoaned for its lack of use and magistrates’ general lack of knowledge of the requirement.

PLIAS Resettlement, a community based organisation located in the London borough of Brent, also operates a court diversion and mentoring service. This work is funded as a one year pilot by the Government’s National Liaison and Diversion Development Network. PLIAS provides alternatives to custody by delivering supported care to BME clients within the community. Services include liaison and diversion, advocacy, support and mentoring. Over the course of a one year mentoring

Diversion and learning disability: a case study

Jordan is in his late 20s and is from a North East African background. He lives alone and has led a fairly solitary life. He has also been unemployed for most of his adult life.

Jordan had been arrested, held in custody and appeared before court on numerous occasions. The cause of most of this contact with the police and courts is Jordan's failure to pay London transport fares. Jordan would attempt to jump barriers or slip on and off buses or trains unnoticed. Jordan had received several fines and has often failed to pay them, resulting in further court appearances and sanctions.

After his most recent arrest, probation staff had suspected that Jordan may have some form of mental health problem. He was referred to PLIAS, who after assessing Jordan realised that in addition to suffering mental health problems, he had a marked learning difficulty.

They also ascertained that most of his offending was related to his learning disability and that he did not understand how to obtain the cards or how the fare system worked, felt embarrassed to ask and had no one to advocate for him or to explain such things to him.

PLIAS staff were able to explain this to the magistrates, who in turn were happy to divert Jordan to their service. PLIAS assigned Jordan a mentor who has worked with him for over a year now, supporting him in developing living skills and also in building up a support network.

relationship, trained PLIAS mentors assist their mentees working through a variety of life issues from spiritual, emotional, mental health and learning disabilities to relationship challenges, enhancing work skills and rebuilding self-esteem and confidence. PLIAS has developed a comprehensive mentoring toolkit.

Women

In the main, women serve shorter sentences than men but will face a range of issues that men will not, including the risk that their children may be taken into care, placing them at greater risk of poor mental health. A significant proportion of the BME female prison population comprises foreign nationals. Due to their foreign national status, a presumption is often made in favour of custody rather than treatment or care and they are less likely to apply for and receive bail – an outcome which may be masking considerable psychological and emotional need (Nacro, 2007).

London Probation Trust works with the national charity Together (working for wellbeing) to provide a forensic mental health practitioner service (FMHP) across a number of London boroughs. The FMHP service aims to:

- increase diversion of vulnerable offenders with mental health needs
- provide appropriate and timely specialist advice to the court
- reduce inappropriate court requests for psychiatric reports
- reduce the number of remands or time spent on remand for offenders with mental health needs
- facilitate appropriate sentencing outcomes.

Together have three gender-specific practitioners who work with women coming before magistrates at Camberwell Green, Westminster and Thames courts. This is the Women's Court Liaison and Outreach Service. A practitioner is in court each day and carries out a pro-active holistic assessment of all women, designed to identify specific needs.

The practitioner we spoke to told us that approximately 60% of her client group were from BME communities. She noted that there could be difficulties booking interpreters at court and when they were successfully booked, assessments inevitably took much longer to carry out. Furthermore, when family members put themselves forward as interpreters it was not always straightforward to work out the family dynamic and whether there might be a conflict of interest. The women's practitioner worked in partnership with St Mungo's to provide housing support and generally found the court to be very supportive of her advice in mental health related cases. The holistic approach also involved families and carers

"This group of women have a lot of complex needs and personality disorder issues. Many have had bad past experiences with services, or don't know how to access services. Homelessness is the main reason these women are unlikely to be granted bail."
(FMHP Practitioner)

Women coming to the project are tracked for a period of two years which is only made possible by the practitioner working closely with other services. Court outcomes are recorded, as well as signposting outcomes and whether or not outreach is delivered.

Hibiscus is a branch of the Female Prisoners Welfare Project and provides emotional and practical support to Foreign National, EU National, BME and Refugee Women (including women seeking asylum). Hibiscus helps women reach and maintain contact with their families and children abroad. Staff ensure that clients understand the British CJS and their rights within it and that all women have access to appropriate services upon their release.

Release from prison

Men recently released from prison are eight times more likely to commit suicide than the general population and women are 36 times more likely (Pratt *et al.* 2006). To ensure that prisoners with mental health problems and

learning disabilities access support on release and achieve effective rehabilitation there needs to be greater emphasis on 'through the gate' services.

St. Giles Trust offers a range of quality services, including support for people exiting prison. The Meet at the Gates scheme utilises Peer Advisors who are recruited and trained to NVQ level while serving prison sentences so that on release they can use their skills and first-hand experience to assist others. In addition, women leaving HMP Downview, Bronzefield or Holloway prison can be referred to the Wire Women's project. St Giles staff carry out an assessment inside prison and meet the client at the gate on the day of release. Staff will then be able to address a range of issues, such as substance misuse, child custody and domestic violence. Following a recent evaluation this project was found to reduce reoffending among women clients by 45%. Although these interventions do not prioritise mental health problems or learning disabilities, by the very nature of the client group and the range of issues involved, mental health and wellbeing are consistently brought to the fore. Therefore, a significant number of St Giles Trust staff have attended mental health training courses on awareness and conducting assessments. St Giles Trust does not provide services solely for BME clients, however they do espouse an ethos which appears to resonate with BME service users.

"We have a number of projects and on all of them 40% plus of our staff are ex-offenders. Ex-offenders go across the organisation, from reception to trustees. That's our ethos, that's our strap-line. Some of the best placed people to help reduce re-offending are those people who have managed to do that for themselves."

(St Giles Trust staff member)

Many young Black men, in particular, involved in the CJS have been through a series of systems that have failed them, including the education system. However, this does not mean they do not have the ability or aptitude to attain qualification and empathise with others as Peer Advisors.

Core components of effective engagement with BME communities

From our discussions with practitioners the following five components emerged as key to achieving positive outcomes.

1. Cultural competence

Cultural competence involves taking into consideration an individual's background.

“We don't just see people as individuals; we see them as part and parcel of their background. So that would be taking into consideration their community, their migrant journey if there is one or their migrant past. So that would be taking into account slavery or any other thing that they would've experienced generationally but also their families. The family's very much in the room as well as the community and also more and more the issues around spirituality and sexuality are coming into the fore as well.”
(Nafsiyat staff member)

Due to a lack of cultural competence, decision makers may be pathologising certain cultural norms.

“Yes, it's important that we explain to professionals, including the police, about cultural practices, so that cultural behaviours are not added on to the list of symptoms, for example needing a cup or a bottle for cleaning in the toilet, or recitation of words.”
(Pakistani Resource Centre staff member)

2. Person-centred intervention

Personalisation entails that services are tailored to the needs of the individual, rather than delivered in a 'one size fits all' fashion. There is an acknowledgment and understanding of diversity of need, and families and carers are more readily involved. The emphasis should be on dignity, humanity and respect.

“When people walk through the door we don't work with their diagnosis. We work with them. Sometimes practitioners work with the label and miss the opportunity to work with the person.”
(ACCI staff member)

The experience of many service users of previous mental health services has been of an exclusive focus on mental health problems and a preoccupation with exclusion criteria.

There is an argument that services should reflect the community they serve and comprise of a diverse workforce, which is representative in ethnicity and gender. The rationale is that BME clients and female clients will often feel comfortable accessing services where the staff group reflects their background, resulting in a better quality of engagement and interaction between client and practitioner (Nacro, 2009). However, the primary concern of many service users is receiving high quality, person-centred services, rather than services that happened to be BME led:

“People just want to be treated well. You don’t always need a Black person to look after you, you need someone who’s respectful. When you’re at your most vulnerable, when your mental health is completely shot – how much more vulnerable can you be? This is compounded when the courts are making decisions about you; it’s compounded when you don’t speak the same language... basic respect is the starting point.”
(SACMHA staff member).

3. Holistic engagement

Some BME communities occupy particular positions of disadvantage and individuals with mental health problems or learning disabilities in the CJS can harbour a number of unmet and often basic needs, including insecure housing, addiction issues and child care requirements. Thus, in order to realistically improve and meet a person’s mental health and learning disability needs and reduce subsequent offending, it is essential that services work holistically.

“We work holistically, not only do we provide CBT but we also provide person-centred counselling, self-help, information and advice and sign-posting... BME communities, especially the African Caribbean community, need a sense of a holistic intervention. We need to look at unemployment, parenting, ill-health and physical long-term health conditions, and importantly, racism.”
(ACCI staff member)

The services we visited tended to adopt a problem solving approach and were not just focused on the service users’ mental health problem; this was clearly attractive to service users and supported their engagement.

4. Mentoring and service-user involvement

Mentoring and service-user involvement are most effective for BME clients when part of a number of supportive interventions. This echoes the findings of the Bradley Report (2009) where the influence of this approach in reducing reoffending was described. Central to the work of all the BME community agencies we engaged with was the involvement of service users and the ability to incorporate their expertise, ideas and energy into the decision making and agenda setting of the organisation.

5. Working in partnership

Clearly BME-led initiatives cannot and should not be the only appropriate provider of services for BME communities but by developing links with a range of potential providers, initiatives would be best placed to access the most effective outcome for their BME clients. The creation of formalised links with BME community-based organisations can assist non-specialised liaison and diversion services to contextualise information during assessments, assist with translation, act as an onward referral and provide a link with other services. Without communication with community-based services, BME people with learning disabilities are unlikely to be identified unless their behaviour gives cause for concern (Loucks, 2007). The community agencies we spoke to were keen to stress that links between community agencies were as important as those between them and the statutory sector. This is consistent with the findings of Breaking the Circles of Fear (Keating, 2002).

Recommendations

This report has gathered examples of initiatives that are effectively engaging BME communities with mental health problems and learning disabilities and achieving positive results with those at risk of being or already involved in the CJS. The following recommendations reflect our findings and are intended as a checklist for liaison and diversion services working with BME communities along the CJS pathway and their partners.

1. Local police, health and BME community-based groups should work together, via mental health and learning disability link workers, to ensure that low level offenders with mental health or learning needs are, where appropriate, referred out of the CJS at as early a stage as possible.
2. Established liaison and diversion initiatives should ensure that they proactively partner local BME mental health and learning disability community-based groups so that expertise can be shared and appropriate account is taken of cultural issues during key elements of the process, such as assessment. Partnerships should be underpinned by referral and information sharing protocols.
3. Established schemes should ensure that BME service providers and local community-based BME mental health and learning disability organisations are part of the schemes' governance and consultation arrangements.
4. A comprehensive mentoring programme for people leaving custody with mental health problems or learning disabilities and returning to the community should be established by the probation service.
5. The data collection and monitoring processes of all schemes and initiatives should be governed by a minimum data set which includes not just ethnicity but also faith and preferred language.
6. Schemes should ensure that they act on data collected. It is not sufficient to simply record data, it should be collated and analysed to gain a picture of how the scheme is operating; assess whether it is reaching the range of potential service users and to what extent it is meeting need. Schemes should ask: does our service reflect the local community and also the flow of people through the part of the CJS where we are located?
7. Service users and carers should be represented at all levels, not just within community-based agencies but also within statutory agencies responsible for commissioning or providing liaison and diversion.
8. Community organisations and liaison and diversion schemes should jointly provide training to court personnel and sentencers about the alternative decision making available to them and the nuances of BME mental health and learning disabilities.
9. Greater use of the expertise of community based agencies should be made in prison establishments and there should be an expansion of 'through the gates' schemes and a similar impetus given to the use of 'peer advisers' within prison settings.
10. Commissioners should give greater consideration to the commissioning of specific community-based services working with BME offenders at all stages of the pathway and to gender specific liaison and diversion services (Salway, 2013).

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- Chief Constable Simon Cole – ACPO lead for Mental Health and Disability
- Sean Duggan – Chief Executive, Centre for Mental Health
- Lady Edwina Grosvenor
- John Lock JP – Council Member, Magistrates Association
- Gen the Lord Ramsbotham, GCB, CBE – former Chief Inspector of Prisons
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The Bradley Commission

Briefing 1: Black and Minority Ethnic communities, mental health and criminal justice

Published September 2013

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Deryck Browne and Dr Graham Durcan.

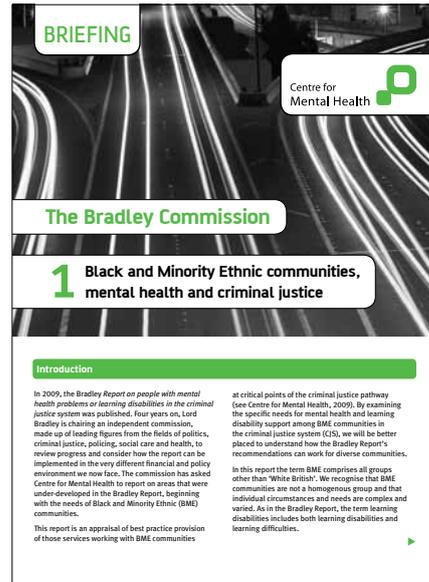
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