changing lives
reducing crime

Black communities, mental health and the criminal justice system

Contents

Nacro believes that responses to mentally disordered offenders should focus on their care and treatment rather than on punishment. To help bring about this change, Nacro campaigns for:

- more effective working partnerships between agencies
- the development of specialist skills in the criminal justice system
- better information sharing
- the education and training of staff so that they have the skills and encouragement they need to work with a group who can be difficult and unrewarding.

Nacro's Mental Health Unit has been working to tackle problems faced by mentally disordered offenders since 1990. We work with government agencies at a national and local level to develop more effective ways to deal with mentally disordered offenders. We provide a range of services: information and advice; policy development and other consultancy services; and training. We also run a major annual conference on mental health and crime.

Nacro has a specialist mental health website which offers information and support for practitioners and policy-makers working in the field of criminal justice and mental health. To find out more, visit www.nacromentalhealth.org.uk or contact the Mental Health Unit on 020 7840 6718, 020 7582 6500 or at mentalhealth@nacro.org.uk

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Introduction

Research studies and data monitoring have consistently shown that of all the black and minority ethnic (BME) groups in Britain, those from black communities in particular are disproportionately represented in both the criminal justice and the mental health systems.[1] This anomaly is compounded by the fact that both systems seriously disadvantage black people once within their remit. This briefing examines the extent of these two interconnected problems, the underlying causes and recent policy and strategy developments, before making recommendations for change.

Despite various policy initiatives in recent years, little progress has been made in tackling this important subject. Home Office statistics have consistently borne out the discrimination experienced by black people who come into contact with criminal justice agencies and the Department of Health has admitted that there is an undue emphasis on coercive models of treatment for black mental health patients, with organisational requirements often taking precedence over their individual needs.[2] Figures show that black people are increasingly over-represented at each heightened level of security in the psychiatric process from informal to civil detention, and then in detention on forensic sections within the courts and criminal justice system.[3] Moreover, the fact that there are such high numbers of black people coming into criminal justice settings, coupled with the discrimination they experience once there, result in the criminal justice system often acting as a gateway to the mental health system for many black offenders. Indeed recent figures show that black communities are over 40% more likely than average to be referred to mental health services through the criminal justice system.[4] With this in mind, this briefing looks in particular at black mentally disordered offenders who are exposed to both systems.

Given the unequal treatment and over-representation that exists in both these fields, it is crucial that the health, criminal justice and social care agencies find ways of working with black communities to address these problems. In focusing on the precise nature of the discrimination in the system, the actual pathways which bring black people into the criminal justice and mental health systems, the type of treatment and care black mentally disordered offenders receive as well as shortcomings in current policy, this briefing seeks to create further awareness of this important topic for all those working in the system, as well as making suggestions for practitioners in order to improve practice.

The criminal justice system

Discrimination from criminal justice agencies

Home Office statistics produced annually under section 95 of the *Criminal Justice Act 1991* reveal the extent of the disproportionate involvement of black people with criminal justice agencies as suspects, defendants and prisoners. To fully appreciate the implications of the following figures, it should be remembered that of the population in England and Wales, just 1.1% are Black Caribbean, 0.9% are Black African and 0.2% are from other black groups.[5] The statistics for 2004-5[6] show that:

- Black people were six times more likely than white people to be stopped and searched under section 1 of the *Police and Criminal Evidence Act 1984* compared to Asian people who were twice as likely as white people to be stopped and searched.
- Searches recorded by police under section 60 of the *Criminal Justice and Public Order Act 1994* show that 56% of searches were of white people, 24% were of black people, while 17% were of Asians.
- Of the searches made under Sections 44 (1) and 44 (2) of the *Terrorism Act 2000* 73% were of white people, 8% were of black people and 11% were of Asians, with 5% being carried out on those of 'Other' ethnic origin.
- Of the 1.3 million arrests made for notifiable offences, 9% of them were black people, 5% Asian people and 1.5% came from 'other' ethnic groups.
- Black people were more likely than white people to be committed at magistrates' courts to be tried by a jury at the Crown Court.
- The proportion of black prisoners who are British nationals in the prison population is five times higher than for white people.

In addition, higher proportions of black people (particularly young people) were likely to be stopped by police, arrested and once arrested, less likely to be cautioned. Similarly, black people were more likely to be remanded in custody, more likely to plead not guilty and where found guilty they were also more likely to receive longer custodial sentences than their white contemporaries.[7] Even before coming to trial, an analysis of 13,000 case files carried out by the Crown Prosecution Service found that there were more likely to be objections to bail for black males than for white males.[8] Figures such as this reveal that black communities are over-represented at each stage of the criminal justice process from initial contact right through to sentencing.

There are various criminological explanations as to the root of this anomaly which include police discrimination, socio-demographic factors, and the fact that black people who have previously committed offences are known to the police and are therefore perhaps more easily detected. However, the figures cannot just be explained away by the notion that black people are more likely to offend than other groups.[9] Indeed the lifetime offending rate for black males is in fact significantly lower than that for white males.[10]

Gender

Given that there are higher rates of black women in prisons than men, and that there is a higher incidence of black women within psychiatric care than white women, it is concerning that examination of the needs of black female mentally disordered offenders is so conspicuously absent from research literature and policy initiatives. In June 2004, the percentage of foreign national women in prison made up 25% of the female prison population. Notably, over 50% of female foreign national prisoners were from Jamaica with over 90% of these receiving custodial sentences for drug importation.[11] Usually minor players in considerably larger operations, these women undergo the trauma of separation from family, children and their homeland for what are often very lengthy periods, which is bound to have a debilitating effect on their mental health.

Immigration and asylum

Indeed foreign nationals make up one third of all prisoners who are either black or minority ethnic.[12] The proportion of foreign nationals amongst the number of black mentally disordered offenders is likely to increase further in future, given the introduction of the *Asylum and Immigration Act 2004* which has, for the first time, made it a criminal offence for someone to enter the UK who does not have a passport or who has destroyed travel documents or who, once within the UK, refuses to co-operate with arrangements for their removal. Those claiming asylum or refugee status are likely to have undergone considerable mental stress and trauma and, if this is not effectively addressed, the trauma of the asylum experience could potentially bring to the surface any latent distress they may have experienced previously.[13]

Resettlement

Discrimination experienced within the criminal justice system is compounded for many black people by difficulties they encounter following release. A 2005 study by Nacro found that black prisoners are less likely than their white

counterparts to seek out resettlement services based within prisons.[14] Where black prisoners experience problems shared by the general prison population such as drug or alcohol dependency, family breakdown or poverty, their impact is further compounded by racism in its various forms which will intensify the difficulties they face in being resettled upon release.[15] For example, while homelessness is a problem for many groups, a disproportionate number of black households figure in the homelessness registers of local authorities and historically discrimination against black people has played a part in the allocation of housing stock.[16] The result is that black offenders can end up being excluded and marginalised from mainstream society at a vulnerable time in their lives, which is likely to aggravate any mental health problems present or even lead to their onset.

The mental health system

Routes of referral

The 2005 Healthcare Commission census[17] of mental health patients in England and Wales, carried out in conjunction with the Mental Health Act Commission and the National Institute for Mental Health in England (NIMHE), revealed that around 9% of inpatients were black, despite the fact that black people comprise just 2.2% of the population according to government figures.[18] The 2006 census found too that admission rates for black people into mental health care were higher than for all other groups, being three or more times higher than the average.[19]

In recent years however, the debate has shifted from a focus on the over-representation of black people in the mental health system to increasing investigation of the ways in which they come to be there. It has been found that black people are more likely than white people to experience 'an aversive pathway into mental health services' by means of higher compulsory admission rates to hospital, greater involvement in legal and forensic settings, and higher rates of transfer to medium and high security facilities.[20] Research into decision-making in the criminal justice system has shown that professionals often more readily associate black defendants with a sense of danger. One study on black people and the courts, during which a series of interviews was conducted with criminal justice officials including magistrates and probation officers, found that they are 'more likely to err on the side of caution with black mentally vulnerable defendants and to be affected by a heightened perception of dangerousness'.[21] Another study into the operation of the civil sections of the *Mental Health Act 1983* (MHA) found too that police officers are prone to associating black people with risk factors,[22] with the result that black people are more likely to be detained by police under Section 136 of the MHA and taken to a 'place of safety' within the meaning of the Act – often a psychiatric hospital – thereby opening that channel into the psychiatric services. Data collected from four Metropolitan Police Basic Command Units during 2005 bore this out showing that a high proportion of Section 136 detainees were black.[23]

The Healthcare Commission census of the same year which looked at 34,000 mental health patients found that black people are in fact 44% more likely to be detained under the MHA than average.[24] This is largely due to higher than average detention rates under section 37/41 of the MHA, where a person is sent to hospital for treatment via the courts under a restriction order by the Home Office.[25] Indeed black patients have been found to be almost twice as likely to be referred for treatment via the courts.[26] Similarly, a study by Nacro established that black people appearing before magistrates were more likely to be remanded in custody for psychiatric assessments and for longer than their white contemporaries, with black defendants also more likely than white defendants to be made subject to hospital orders and psychiatric probation orders. The study concluded that the criminal justice system is one of the key pathways via which black as well as minority ethnic groups enter the psychiatric system, particularly younger black men.[27]

Prison in particular acts as a common point of referral to mental health services for black people, with black prisoners more likely than white counterparts to be referred from prison establishments to psychiatric units.[28] Cope and Ndegwa[29] found too in a comparison of white and black patients admitted to a regional secure unit, that black people were significantly more likely to be referred from the prison system while on remand, whereas white patients were more likely to be admitted from the NHS or special hospitals.

Despite the existence of evidence such as this of the high rate of black people passing from the criminal justice system into the mental health system, it remains the case that statistical bulletins produced by the Home Office on mentally disordered offenders are not broken down by ethnicity, which is a serious omission.

Treatment and care

Once within the mental health system, the overwhelming evidence is that black patients' experiences are more negative than those of white patients. Racism, cultural ignorance and

stereotypical views can often combine with the stigma and anxiety associated with mental illness to undermine the ways in which mental health services respond to black communities, affecting decisions about treatment, medication and restriction. NIMHE has noted the disproportionately high rate of schizophrenia diagnosed among black mental health patients and the fact that black patients generally remain in hospital on a section for longer than their white contemporaries.[30]

The fact that there are disproportionate numbers of black people coming into the mental health services from a criminal justice context means that this group of mentally disordered offenders is often viewed by staff as presenting an increased security risk compared to that posed by other groups. A study into decision-making in the mental health sectioning process showed professionals made a strong link between black patients and a notion of heightened risk,[31] with the result that additional safety precautions were frequently seen as necessary. For example approved social workers (who play a key role in the civil sectioning process) are more likely to request a police presence when taking a black patient to hospital. Prins *et al* whose inquiry examined the treatment of black mentally disordered offenders found they are also more likely to be detained in the locked wards of psychiatric hospitals and more likely to be transferred to higher security facilities (and for longer) than white patients.[32]

NIMHE has also found there is a greater likelihood of the use of coercive treatments for black patients than white.[33] Figures for 2005 show that black patients are more likely to experience physical seclusion and restraint than other groups,[34] with the most recent figures for 2006 revealing a particularly high rate of hands-on restraint for this group.[35] Set against this backdrop, it is perhaps unsurprising that black patients are also less likely to receive benign forms of psychotherapeutic treatment such as psychotherapy and counselling than their white counterparts and more likely to receive higher doses of medication, being 'often subjected to heavy doses of drug cocktails which has led to deaths in HM prisons and special hospitals'.[36]

Inquiries such as those into the death of Orville Blackwood have raised concerns about the use of such force and increased medication as a means of controlling the perceived increased security risk associated with some black patients. Furthermore, the government has openly admitted the scale of the problem. In February 2004, in a speech in response to the publication of a report into the death of David Bennett, a black patient who died in a medium secure setting after being restrained by staff, the then Secretary of State for Health conceded there was both direct and indirect discrimination in services, admitting 'Behaviours and processes that have grown up in mental health services mean that there is particular inequity in the provision of care and outcomes for people from black and ethnic minority groups.'

Alternative services

The use of inappropriate treatment and discriminatory processes within mental health services is not a recent phenomenon. In the late eighties and early nineties, there was increasing discussion on providing more appropriate treatment and care for mentally disordered offenders in hospitals and care settings, as expounded in the Home Office Circular of 1990 *Provision for Mentally Disordered Offenders.*[37] But by this time, given the disproportionately high use of psychiatric remands by magistrates and a similar trend in the use of transfers from prison to secure mental health settings, many black communities and mental health groups had become increasingly aware of the risk of a 'double jeopardy' scenario where diversion could effectively mean the transfer from one potentially discriminatory and damaging system to another. They realised there might actually be too much diversion from criminal justice to psychiatry for black people without the actual benefit of them then receiving appropriate treatment and care. In response, some black communities started developing their own distinct services.

One such initiative was established in the Midlands which strove to divert African Caribbeans away from psychiatric hospitals to community settings at their first point of contact with the psychiatric services.[38] Intense support was provided to patients at a location of their choosing and both users and carers were closely involved with the process. Admissions to hospital for the client group in this locality were significantly reduced during the life of this initiative. While this alternative is not necessarily appropriate for all mental health patients, it illustrates the fact that black communities were sufficiently disaffected by existing provision to implement alternatives, and serves as an indicator of the additional work that needs to be done by criminal justice, health and social care agencies to engage black communities and to gain their trust in the mainstream diversion and assessment process.

Following the publication of the report into the death of David Bennett,[39] there has been increasing debate about separate services for ethnic minorities

in general psychiatry and in some parts of the USA, separate in-patient services have been developed.[40] It has been argued that separate services might better serve black, as well as other minority ethnic, patients and there might perhaps be increased emphasis on communicating (between patient and practitioner) in a culturally informed way.[41] The counter-argument is that the creation of separate services risks the development of a division between those professionals who 'know' how to treat and care for patients from minority groups, and those who 'do not know'. The creation of separate services would appear to be an admission of failure, not only of the current system's ability to provide adequate support and training within existing psychiatric services, but also of its ability to address the fundamental question of why black patients, and especially black mentally disordered offenders, are treated differently to white people in psychiatry.

Government strategy and policy development

The Reed Review

In the early 1990s *The Review of Health and Social Services for Mentally Disordered Offenders* (known as the 'Reed Review') by the Home Office and the Department of Health reported its findings. In its 1994 volume entitled *Race, Gender and Equal Opportunities*, it recognised that African Caribbeans were experiencing particular problems (as distinct from those encountered by BME communities as a whole) and that therefore their involvement was crucial for improving service provision for the future, stating:

> *'It is important that diversion schemes provide a service which is appropriate and acceptable. This will require the involvement of members of the Afro-Caribbean community in developing the service, as well as the involvement of staff who are sensitive to the issues of race and culture and the implications of socio-economic disadvantage for ethnic minorities.'* [42]

It is significant that over a decade after the Reed Review, the over-representation and discrimination experienced by black people in the mental health system has still not been effectively addressed. However, there have been some strategy and policy developments in this area in the meantime.

'Culturally capable' services

In 2003 NIMHE set out in the progressive document, *Inside Outside*, its strategic objectives for improving mental health services for BME communities in England.[43] These included the need to:

- reduce and eliminate ethnic inequalities in mental health service experience and outcomes
- develop a mental health workforce that is capable of delivering effective mental health services to a multi-cultural population
- enhance and build on capacity within BME communities and within the voluntary sector for dealing with mental ill health

Inside Outside discussed strategic tools that would help realise these objectives and advanced proposals to expedite the development of so-called 'culturally capable services' which included setting national standards to improve access, experience and outcomes for BME users and making research and development more culturally relevant. However, there was little focus on either forensic issues or on the role of the criminal justice system and offending in mental health.

The Bennett Inquiry

The inquiry into the death of David Bennett in 2003 made a series of recommendations which also held implications for the treatment and care of black, as well as minority ethnic, individuals held in secure settings.[44] These included the following:

- All mental health services should have a written policy dealing with racist abuse and records of such incidents should be kept.
- The mental health workforce should be ethnically diverse and, where appropriate, steps should be taken to recruit, retain and promote staff from BME communities.
- A national staff training programme in restraint and control methods should be instituted as quickly as possible – and certainly within twelve months.
- No patient should be restrained in a prone position for more than three minutes. All psychiatric units should keep records of the use of control and restraint of all patients. These reports should be audited by the Department of Health.

The recommendations above were accepted without amendment by the Department of Health, with the exception of the final one. (The wording preferred by the government in its response to the fourth recommendation was that any physical intervention should be used only as a last resort, in the safest way possible, and for the shortest period of time that is necessary for patient and staff safety.)

These recommendations and others, by virtue of the fact that they cut across mental health care in general, will consequently impact on black people with mental health problems who are also involved in the criminal justice system. But it remains the case that provision for black mentally disordered offenders in particular, has received little specific focus from the Home Office or Department of Health since the commission of the Reed Review over a decade ago.

Working together

Delivering Race Equality in Mental Health Care (DRE), produced by the Department of Health in 2005,[45] proved a useful document as it recognised that in the debate about black over-representation in mental health, a shift had generally taken place away from notions of deviancy, dangerousness and genetics and towards socio-cultural explanations in line with the concept of 'institutional racism'.[46] Certain authors, such as Fernando[47] had been espousing similar concepts for some years. However the shift was important, as it broadly mirrored the parallel development in the field of race and criminal justice where, in the light of the MacPherson Inquiry Report into the death of Stephen Lawrence, criminal justice agencies (principally the police) began to accept the concept and existence of institutional racism and to modify policies and procedures accordingly.

Importantly, DRE set out a national strategy for greater community engagement and partnership work between mainstream and statutory services on the one hand, and black and other minority ethnic community and mental health groups on the other, in recognition of the key role the latter have to play in the development and provision of services. It resolved to recruit 500 community development workers nationally who would be expected to work at a senior level and alongside the regional Race Equality Leads within health and social care, focusing on improving commissioning, access, experience and outcomes for all ethnic minority communities. It also recognised the need for statutory services to be involved in:

- forming partnerships with faith communities
- ensuring that representatives of BME voluntary sector partners are of comparable seniority to statutory sector representatives
- commissioning BME specialist services on the basis of needs assessment and overall service strategy
- identifying BME voluntary sector groups that might be potential candidates for Treasury funding or section 64 (Department of Health) grants
- practically supporting the capacity of BME groups to become involved in the planning, designing and delivery of services
- putting in place mechanisms to facilitate mutual learning between BME-delivered services and mainstream services

This is a useful framework for engagement and has echoes of a recommendation from the Reed Review which stated that: '…all agencies involved with mentally disordered offenders should establish strong pro-active equal opportunities policies relating to race and culture which should be reflected in staff training and allow for consultation with representatives of ethnic minority groups in the planning, development and monitoring of services.'[48] However, while community engagement is central to the arguments within DRE, it should be noted that it did not specifically relate the arguments and recommendations to mentally disordered offenders from black or minority ethnic groups. When developing ways of working in partnership to provide services and engaging with service user groups, it is important that black community groups are not perceived as being relevant solely to issues seen as tangible 'black' issues, and that there is also an awareness of race and faith considerations.

New initiatives

There are some new initiatives underway though to improve services for mentally disordered offenders. Health and Offender Partnerships (HOPs) is a partnership directorate between the Home Office (NOMS) and the Department of Health (Care Services Directorate). HOPs includes the Home Office Mental Health Unit and Prison Health at the Department of Health and its core initiative is to tackle health inequality and reduce offending. Currently, it is developing an offender health strategy which focuses on all parts of the criminal justice system, including the large body of offenders being supervised in the community. However, the key test in respect of approaches to mentally disordered offenders from the black community will be whether this development will be able to marry some of the innovative ideas from initiatives such as DRE with the more mainstream thrust of HOPs.

Effecting change

Bringing about change in the future will require a concerted and systematic approach: there needs to be a new drive towards working in partnership with

black groups, and an improved focus on the development and delivery of services. To achieve this, reform needs to focus on the following three areas

- Changes in monitoring and funding procedures.
- Increasing staff and practitioner awareness of the needs of the black community and a renewed commitment to dealing with their needs effectively and fairly.
- Successfully engaging and fully involving black communities in the reform of services.

Monitoring and funding procedures

The precursor for any initiative developed, however, is the need for robust ethnic monitoring data across both systems. To improve both monitoring and funding procedures, the following measures need to be implemented:

- All criminal justice and mental health agencies should adhere to the ethnic category data guidance produced by the Department of Health and statistics collected by the Home Office on mentally disordered offenders should be broken down by ethnicity.
- Criminal justice mental health liaison schemes (and in particular court-based schemes) should have rigorous, effective ethnic monitoring procedures in place which collect useful and comparable data.
- The data, once collected, must be properly analysed and made available to funders, scheme steering groups and strategic multi-agency forums (where they are in place) who must then be prepared to act on the data provided in order to improve services for black communities.
- Resources and funding should be made available both from the centre and locally, so as to minimise barriers to the implementation of recommendations made by mental health and black community organisations, and other relevant bodies.

Increased awareness of staff and practitioners

Staff working with black mentally disordered offenders have a crucial part to play in improving services. Making good practice guidance available to staff and practitioners in this area would greatly assist this process. Resettlement work and work with black female mentally disordered offenders are two areas where improving practice is particularly important.

It is vital that resettlement staff work alongside families and community and faith groups so that successful programmes can be developed. In addition, it is imperative that staff build strong links with black mental health and community groups and service user groups, so that staff can notify them of any mental health problems or feelings of exclusion due to ethnicity which black ex-offenders might be experiencing.

Practitioners need to be aware too of the many prejudices that female black mentally disordered offenders face in particular. In light of this, they need to take into account the following issues in their practice:

- The resettlement needs of black women.
- The planning and development of community provision for black women.
- The needs of women asylum seekers and those seeking refugee status.
- Engaging black women's groups when building and sustaining partnerships with voluntary sector groups.
- The trauma caused by separation from their families and children for black women detained in the criminal justice and mental health systems, especially for foreign national women whose families and children may live in a different country.

Working in partnership with the black community

To achieve better outcomes for black mentally disordered offenders, primary care trusts and mental health trusts should consider taking the following steps:

- Involving black community and mental health groups in the development and running of court-based diversion, liaison or assessment schemes.
- Ensuring local mentally disordered offenders' steering groups include representation from a relevant local black mental health or community group, in order to include a black perspective on the development of strategic plans for services for mentally disordered offenders.
- Involving local black community and mental health group representation in Section 136 MHA monitoring groups.
- Encouraging the creation of an effective and authoritative association of black service users.
- Involving black health groups in a wide range of issues rather than solely with what are considered to be 'black' issues.

Conclusion

There is clearly a continued need for government departments and criminal justice and mental health agencies to tackle the many difficult issues that persist in the relationship between black communities, criminal justice and psychiatry. The key strategy documents of recent years have added little of substance to the material produced in the last two decades and many have avoided the focus of black mentally disordered offenders altogether. Not only is progress needed in the key areas mentioned above (eg rigorous ethnic monitoring in court diversion and criminal justice liaison schemes; greater black representation on scheme and section 136 steering groups; central monitoring of the ethnicity of black mentally disordered offenders; improved service delivery and better community engagement) but there is also a need for a concerted and inclusive strategy towards black and minority ethnic mentally disordered offenders which cohesively tackles the particular problems they experience in areas such as immigration, asylum and resettlement. Given that the criminal justice system can act as a gateway to the mental health system, the need for comprehensive action that reforms both systems is all the more pressing. The danger, if this does not happen, is that policy-makers in this field will find themselves perpetually addressing the symptoms rather than the causes of these inequalities.

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