

Wednesday 30th April 2008

# 'Informing Commissioning'

**GMCVO**  
St Thomas Centre  
Ardwick Green North  
Manchester  
M12 6FZ

10.00am – 1.30pm

## **Commissioning Appropriate and Responsive Services for BME Offenders**

**Survey across Prisons, Secure Services and in the  
Community in Greater Manchester**

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Special thanks are given to:

Stephen Brook, North West Secure Commissioning Team  
Manjeet Singh, Regional Race Equality Lead CSIP North West  
Najam Asghar, Partners of Prisoners and Families Support Group  
Maya Simmons, African and Caribbean Mental Health Services  
Sana Riaz, Pakistani Resource Centre  
and Viveen Taylor from the National Body of Black Prisoner Support Groups.

Most of all we would like to thank the participants who willingly shared their experiences to make this survey possible.

# **Commissioning Appropriate and Responsive Services for BME Offenders**

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## **INTRODUCTION**

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In 2007 Secure Commissioners in the North West Specialised Commissioning Team (NWSCT) tendered for additional contracts for Medium and Low secure mental health inpatient services in Greater Manchester. As there are significant numbers of Black and Ethnic Minority (BME) patients in secure services in out of area placements it was decided to look at how the needs of this group could be better met in relation to the tenders and future provision of services.

They approached the Care Services Improvement Partnership (CSIP) North West and following discussions it was agreed to commission a piece of work to review the mental health needs of BME of offenders in both community, prison and secure settings.

This work is intended to support national policy in implementing the action plan from the Department of Health Delivery Race Equality in mental health care which is founded on the three building blocks of

- Developing more appropriate and responsive services
- Increasing community engagement
- Developing better quality information

In order to undertake this work the following three BME voluntary sector organisations were each commissioned to carry out a survey of 30 offenders from Greater Manchester who had an offending history. These were:-

Pakistani Resource Centre (PRC)  
Partners of Prisoners and Families Support Group (POPS)  
African and Caribbean Mental Health Services (ACMHS)

In order to ensure a consistent approach an anonymous structured questionnaire was developed that was used by all organisations and this forms the basis of the findings of this report. (See appendix 4)

NWSCT and CSIP North West would like to thank the following organisations for their assistance in carrying out the survey on offenders

- HMP Haverigg
- Greater Manchester West Foundation Trust (Edenfield Centre)
- Equilibrium Healthcare
- Partnership in Care (The Spinney)
- Local Community

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## **WORKING IN PARTNERSHIP**

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A steering group was established to develop, monitor and provide governance for this project. The three voluntary sector organisations (PRC, POPS and ACMHS) identified a project facilitator to interview offenders and completed 90 questionnaires in community and secure settings and have produced sets of data and reports with findings and recommendations which follow.

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## **METHODOLOGY**

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The project steering group agreed to each of the voluntary sector organisations completing 30 interviews each. A questionnaire was developed to be used for 1-1 interviews and where appropriate focus groups, qualitative and quantitative data was collected. An information sheet was made available to all participants.

The voluntary sector organisations agreed to complete the interviews in community, prison and secure settings.

In relation to secure mental health services, ethics approval was agreed through the Governance Department of Greater Manchester West Foundation Trust.

## **Services for Prisoners survey carried out by Najam Asghar on behalf of Partners of Prisoners (POPS)**

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### **ABOUT POPS**

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POPS is a registered charity set up twenty years ago by families who were experiencing having a loved one in custody and who formed themselves into a support structure for each other when there was nothing else available. Today, we have grown to be an Organisation with over sixty-five full and part-time staff, delivering appropriate services to families at various stages of the criminal justice process. We operate locally within the community, regionally within the North West and nationally as a partner in a national telephone helpline. We are members of various steering groups, working parties and strategic boards and provide a family perspective at all of these forums.

In addition to running 7 Prison Visits Centres across the North-West, which includes the provision of Prison based Family Link Workers; POPs also have a history and portfolio of work that relates to supporting, advising, assisting and training Black Prisoners and Ex-Offenders in the Criminal Justice System.

In 1998 we developed the Black Prisoner Support Project. The service was developed in response to the needs highlighted by Black families trying to support a Black offender in the Criminal Justice System. Initially we had dedicated caseworkers helping Black offenders in prisons across the North West. Then we developed the service to include mentors helping Black offenders on community-based license's or on release and returning to the Manchester area.

We have, amongst other initiatives provided Black Prisoners in 6 prisons (HMP Lindholme, HMPYOI Moorland, HMPYOI Doncaster, HMP Wealstun, HMP Risley and HMP Liverpool) with monthly facilitated group work sessions with the specific aims of improving Race Relations between prisoner and prison officers, provide Black men with an understanding of their culture and help to build confidence.

Our current work includes the 'Routes 2 Routes' course, a modular validated course developed by POPs on behalf of IMPACT – a European Social Funded research project led by HM Prison Service.

The 'Routes to Roots' course is designed to empower BME ex-offenders by tackling issues of racism and addressing internalised discrimination often faced by this group. The course involves participants sharing their various cultures, historical learning and personal experiences by providing a 'safe environment' in which they can speak openly and honestly about issues that matter to them. This course utilises Community Based Facilitators from diverse backgrounds and is based on the concept of 'inter-culturalism', whereby different communities are able to come together to learn more about each other through a process of mutual learning and joint growth.

The Routes 2 Roots course has been independently evaluated and gauged to be a huge success in terms of impacting upon the self-esteem and well being of BME Prisoners.

POPs are also the lead community organisation in a piece of research in conjunction with UCLAN relating to the mental health of young people incarcerated in the Prison System. This work utilises Peer Researchers to undertake one to one interviews with their peers in the prison setting to gauge the level of understanding and provision of mental health services in Prisons. This research is ongoing and is at the preparation of the final report stage.

Raising issues that affect Black offenders is a priority for the POPS Black Prisoner Support Project and the acceptance of the existence of institutional racism in the prison service has been a major step forward. However, there is still a long way to go in order that policy is transferred into practice and we continue to strive towards ensuring equality for Black offenders.

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## **METHODOLOGY**

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As part of this survey, POPs were asked to undertake interviews with Black and Minority Ethnic Offenders in the Prison setting who were from the Greater Manchester area. To do this, POPs liaised with and was supported by HMP Haverigg, a category C Prison in Cumbria with over 600 Prisoners to undertake interviews with the participants. To this end, Derek Ross, the Deputy Governor and Martin Jones, the Diversity Manager were both instrumental in enabling and allowing access to the Prison and the Prisoners.

Information for the survey was gathered through one to one interviews with 30 BME Prisoners held over the course of 2 days by 2 facilitators. In addition to this, 3 focus groups were held in the Chaplaincy area within the Prison. We are grateful to the Chaplaincy staff for their welcome and assistance in enabling the interviews to take place.

The Prisoners had all experienced incarceration in several prisons and the comments they make relate to their experiences of losing their liberty and being incarcerated in the Prison System, and do not relate specifically to the regime, conditions or processes used at HMP Haverigg.

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## **ANALYSIS OF PARTNERS OF PRISONERS SURVEY**

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Following analysis of the data gathered from the questionnaire and the collation of the anecdotal information expressed by the participants elicited from one-to-one interviews and in the focus groups, it is clear that the issues raised by the offenders

fall into several categories. These categories have been grouped as “Process”, “Cultural Needs”, “Health and Well Being” and “Environment”.

## **Process**

In terms of process, the majority of comments related to the Induction Process and the perceived lack of relevant information of Mental Health Services. Participants expressed a gap in terms of the provision of Health information for the prisoner during and after induction, as well as a lack of signposting for the prisoner to support services available in the establishment. Conversely it was also expressed that even if information in relation to health services or simply health information per se were available, the induction process is not always the best time to deliver it. The reason being, that many prisoners have travelled some distance and are not in the right state of mind to receive information, due to tiredness etc.

It was also felt that there appeared to be a lack of health information accompanying the prisoner in order to inform the Prison that a specific issue may exist for a particular prisoner, whether that be in relation to a specific mental health issue or a health issue in general. It was felt that some prisoners were already dealing with mental health issues before they came into the prison and that it was neither identified before or after the incarceration.

## **Cultural Needs**

There was a general consensus amongst the participants that cultural issues or issues that the prisoners view as important that relate to their particular culture, were not dealt with appropriately. Examples given, related to food, both in terms of the lack of culturally appropriate ingredients, and where ethnic food is provided, the perceived lack of quality.

It was expressed that requests for particular products that relate to race, for example, shaving cream for sensitive skin or accompaniments for prayer were not taken seriously. Alongside this, requests to enable Muslim prisoners to pray 5 times a day were not taken into account or given the consideration that those making the request feel it required. The consensus amongst the Muslim participants in particular, was that some prisoners need time to be able to pray individually and that prayer should not be seen as privilege but as right. This lack of understanding led to feelings of anger and frustration and a justification of the view that there is a general lack of understanding of BME prisoners in general.

Although not in itself an issue that is unique to BME families, it was expressed that within the ‘Asian community’ there is a heightened feeling of ‘stigma’ and ‘shame’ for the families and communities of Asian prisoners. It is usually the case that only family and close friends are informed of a period of incarceration. However, sometimes names and offences appear in the local media and this increases the level of shame, particularly where cover stories have been used to explain absences.

## Health and Well Being

It would seem that feelings of stress and pressure are prevalent in the daily lives of the prisoners. These relate to feelings of frustration, anger and depression primarily relating to the incarceration and separation from family and loved ones. It has been found that prisoners per se are placed in prisons that are on average 53 miles from their homes and that 43% say they have lost contact with their families since entering the prison system. This can quite often result in behaviour that follows a route of withdrawal, inner conversations, aggressive manner and attitude, finally leading to aggressive behaviour. Invariably this leads to being disciplined and punished on the basis of physical behaviour but is in reality influenced and is borne out of feelings of stress, depression and frustration.

Although there are opportunities to talk to others about these feelings, in the form of friends, cell mates or those trained by the 'listener service', invariably prisoners do not discuss these feelings. Notions of self-esteem and pride do not allow speaking to others alongside the fear that this may be interpreted as a sign of weakness. This is particularly important in an environment where there is a perception that expressing feelings is a sign of weakness, and may lead to being targeted and 'bullied' by other prisoners.

This then creates somewhat of a catch 22 scenario as not being able to discuss matters with others to relieve feelings of stress and pressure does in some circumstances lead to displays of aggression and 'acting-up'. It was expressed by some in the focus groups that 'weaker minded people could lose their mind because of this and are pushed over the top'.

Many of the participants were of the opinion that the pressure of incarceration leads to behaviour changes because of your mental state, which in turn leads to being disciplined, which in turn leads to you being viewed as a problem prisoner, which in turn leads to increased feelings of stress, frustration and pressure. This in itself creates a negative cycle as you then lose privileges and benefits.

A number of prisoners were unhappy with the healthcare services within the prisons that they had experienced. There was a strong feeling that although you may go to healthcare with legitimate reasons / illnesses, the prevailing view is that you are not taken seriously and that your illnesses are 'bogus'. This leads to feelings of powerlessness and helplessness. This is exacerbated by the view that blocks are put in place in accessing healthcare in the first instance, for example an appointment needs to be made the day before. Therefore, presenting issues such as migraines etc are not dealt with immediately and affect physical as well as mental well being.

The view was expressed by more than one participant that increased levels of stress can and does lead to prisoners taking up smoking and in some instances asking other prisoners for drugs to 'take the pain away'. A third of the participants admitted that they had issues in relation to drugs and alcohol prior to coming into prison and that these issues were ongoing. None of the participants identified the health care service within the prison as assisting them with these issues. There was general consensus amongst the participants that the health services across the prison system were in need of improvement.

## **Environment**

Participants were of the view that being incarcerated is a tense, stressful and pressurised environment with very little opportunity for a release of the build up of tension. It was felt that the Prison staff are not trained to recognise mental health issues and therefore view behaviour change as a behavioural issue and not one borne out of what is going on in one's mind. BME prisoners in particular feel as though they are treated differently than the non BME prisoners and feel as though they are given harsher punishments.

Some discussion took place as to whether the BME prisoner's experience would be better if there were more BME Prison Officers on the staff roll. To some the notion of BME staff was seen as an abstract concept as there are so few of them and it is therefore difficult to gauge what their impact might be. However, others felt that it would be better as there would be someone who has an understanding of the BME prisoner's situation. On the whole it was agreed that what is most important is the connection that is made between the Prison Officer and the Prisoner, regardless of race or culture, that is to say, being approachable and understanding is more effective in engaging prisoners and ultimately impacts on well being.

The issue of visits from family, friends and loved ones was seen as integral to the mental health of the participants. Where prisoners do not have visits regularly or take part in visits that are of poor quality this invariably leads to feelings of isolation and depression and increased stress. One participant gave the example that he had not seen his family or children for 6 months even though he had sent out Visitor Orders enabling them to visit. The reasons given were distance, poor quality of visit due to the décor and layout of room and the way visitors are treated by prison staff and how this affects the visitor's experience. Participants expressed the view that distance from their home was a key factoring influencing their emotional state, as distance invariably influenced the number of visits. Therefore being out of area is a significant factor for the BME prisoners taking part in this survey

Participants who had previously experienced release from prison expressed the view that there is a lack of support in the resettlement process and this exacerbates and heightens the stresses and pressures that one is already feeling. They recognise that they have to adhere to certain conditions and report regularly, but the emphasis here is on compliance and monitoring rather than support in terms of finding accommodation and gaining employment etc. Again some of the issues raised by the participants in relation to the lack of understanding of prison officers in terms of 'cultural issues' was also applied to supervising officers and support agencies in the community. It was also expressed that literature and information relating to the resettlement process was not aimed at those from a BME background.

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## **RECOMMENDATIONS FROM POPS**

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- Information on Health Services given to prisoners both at induction and post induction

- Information should be BME specific where appropriate
- Training for Prison Staff in relation to Cultural Issues – incorporating issues around health and emotional well being
- Cultural sensitivity training for Health Care staff within the Prison Setting
- Access to BME prisoner support groups and/or networks within the prison setting
- Access for BME prisoners to Health and Emotional Well Being courses that incorporate stress management techniques including specific BME issues
- BME mentors on each wing within the prison setting who are trained in issues of emotional well being Review of Visiting process and Visitor experience for BME families utilising the views of both BME prisoners and visitors
- Increased support for Prisoner on release regarding resettlement with BME specific information and literature

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## CONCLUSION

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Identifying the gaps in services and trigger factors that relate to the mental health and emotional well being of BME prisoners and ex-offenders is a complex issue. However, this survey highlights that no one issue on its own affects the well being of prisoners and that no one issue rectified on its own can impact on the mental health of aforementioned prisoners. “One issue alone is not always significant but when a number are added together they become a problem.”

The participants of this survey were clear that ‘mental health’ has attached to it a particular tag of ‘treatment’ and this in itself becomes a barrier straightaway because of the stigma attached. It was also clear that prisoners need more detailed information as to what services are available to them and how they can access them.

Perceptions of how BME prisoners are viewed because of their race, culture or beliefs, whether real or imagined, have to be addressed in order to alleviate the prison experience. Some of this can be addressed through appropriate training for staff, with input from those with appropriate knowledge in the Health services, and through enabling Prisoners opportunities to discuss issues with peers in a ‘safe space’.

Increasing the provision of information of services available in and external to the prisons and providing better support on release will go some way to alleviating the stresses, pressures and frustrations that are often internalized by prisoners and ex-offenders.

**Offenders in Secure Mental Health Services Survey carried out by Maya Simmons, Psychologist on behalf of African and Caribbean Mental Health Services (ACMHS)**

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**ABOUT ACMHS**

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African and Caribbean Mental Services (ACMHS) is a successful community based voluntary organization centred in Manchester. It provides a free confidential and culturally appropriate mental health service to African and African Caribbean people suffering from mental ill health. In addition, it also provides services to their carers and families. It supports over 350 clients per year and operates across economic and socially disadvantaged areas of Salford, Trafford, Manchester and surrounding areas. ACMHS takes a holistic approach to mental ill health, perceiving it to be linked not only to psychology / genetics, but also external factors such as exclusion and isolation.

ACMHS was established in 1989 as a result of concerns expressed by the community about the frequency with which second generation African and African Caribbean youths were admitted to psychiatric hospitals and the regional forensic unit. Concern focused on the way such admissions took place, what happened when people were admitted (in terms of diagnosis and treatment) and what happened after they left in terms of aftercare and housing. A fundamental objective of the organization is to promote mental health issues and support individuals experiencing mental illness to reintegrate back into the community with a view to leading an independent life.

As a registered charity, ACMHS is managed by a twelve member Board of Trustees plus 3 co-opted members who possess a variety of skills and experiences, which are utilised in a number of ways. All paid staff and volunteers are of African / African Caribbean descent.

Our multidisciplinary team delivers comprehensive services to members in the community, hospitals, secure units and their homes, as well as to carers and their families. Currently ACMHS has fourteen members of staff and a team of volunteers, who assist staff to facilitate the drop-ins, provide counselling and befriending services.

ACMHS works to influence and raise awareness of cultural issues and mental health to bring about change by policy decision makers and practitioners and also promote good health in the community. ACMHS encourage, facilitate and assist other voluntary and statutory agencies to develop culturally appropriate and sensitive services by our staff delivering training sessions in universities, colleges and statutory services as well as through the distribution of information and advice.

Service provision includes assessment and management of the individual's mental health, drop-ins, talking therapies, advocacy, information / advice on the Mental Health Act, diagnosis, medication and side effects, benefits and housing advice as

well as practical support such as budgeting and shopping. The drop-in activities which form an integral part of our service, provides a forum for members to gain new skills and widen their social network. Activities include art, Black literature, music, poetry, sports, trips and cultural studies. We also work with prisoners across Greater Manchester and provide placements and training for Social Work students, Occupational Therapists and secondments for health and social care professionals. In addition to this, ACMHS provides through the Aspire Project, support, advice and guidance to service users who are interested in accessing education, training and employment opportunities. We also provide placements for service users who are interested in facilitating classes or administration work within the organization.

ACMHS also has a Primary Care Mental Health Team (PCMHT) working with people 16-65 years old living in Manchester and who have common mental health problems i.e.: depression, anxiety, relationship problems and low self esteem. The Primary Care workers offer brief interventions that focus mainly on current problems and help people develop techniques to manage their problems better.

We work in partnership with other organizations to maximize benefits to service users, whilst at the same time encouraging and facilitating the development of culturally appropriate service provision by other providers.

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## METHODOLOGY

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As part of this survey project, ACMHS was designated to undertake a total of 30 interviews with Black and Minority Ethnic offenders and ex-offenders experiencing mental health problems, who were placed both in the community setting as well as secure hospitals.

Interviews took place between Jan 22, 2008 and March 18, 2008 and were carried out by Maya Simmons, a Psychologist. They comprised mainly of one to one interviews in the community (with 11 participants) and secure hospitals (with 16 clients); and one focus group (consisting of 3 clients) in the community.

The identified hospitals included the following:

1. Bigfoot Independent Hospital, a low secure hospital based in Longsight, Manchester. It is a private hospital, managed by Equilibrium Healthcare. Patients include adult males with Learning Disabilities.
2. Jigsaw Independent Hospital, a low secure hospital based in Didsbury, Manchester. It is a private hospital, managed by Equilibrium Healthcare. Patients include both males and females with mental health problems.
3. The Spinney, a medium secure hospital based in Atherton, Manchester. It is a private facility, owned and managed by Partnerships in Care Ltd., a subsidiary company of the Healthcare Group. Patients include adult male suffering from mental disorders, all liable to be detained under the 1983 Mental Health Act.

4. Edenfield Centre, a medium secure facility based in Prestwich, Manchester. It is an NHS managed hospital. Patients include adult males and females suffering from mental health problems.

Maya liaised with the relevant staff members at the above hospitals, who were in turn identified by Stephen Brook, North West Secure Services Commissioner, and obtained their agreement to conduct the survey. Relevant staff members at each hospital in turn, identified potential participants.

An information sheet (Appendix 2a), outlining the aims, objectives, and other relevant information was provided to each participant at the hospital via the staff members before the interviews. This information was also provided at the beginning of the interviews and read out to those who had reading difficulties.

A similar information sheet (Appendix 2b) was provided to clients in the community.

A written consent (Appendix 2c) was obtained before interviewing the participants for the survey. They were requested to only include their initials on the consent forms in order to maintain confidentiality. Each participant was informed about their rights to terminate the interview at any time without that decision affecting their care in any way. They were also informed that the information provided would remain confidential, except if harm to self or others was identified during the process of the interview.

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## ANALYSIS OF ACMHS SURVEY

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From the information gathered during the survey and the anecdotal information expressed by the participants issues have been broken down under the sub-headings “Impact of ethnicity on service provision in secure units”, “cultural needs”, “mental and physical health”.

### **Impact of Ethnicity on Service Provision in Secure Units**

There was general consensus by the participants on the following:

- Misunderstanding / prejudice / misconstruing of their conversations and behaviours due to lack of cultural understanding and knowledge on part of service providers in secure units - “They are ignorant about other cultures and not open-minded”, “education in cultural awareness is needed for staff”.
- Black people stereotyped as aggressive and dangerous and viewed negatively and with suspicion instead of on individual merits – “some staff stereotype us as being aggressive and as troublemakers when we are not”.
- Black people stood out due to holding different views and behaviours, e.g. talking loudly, being animated, expressive, and standing in close proximity to others when conversing - “We are seen as verbally aggressive because

we speak louder”, “we are viewed as threatening when standing close to others”.

- Institutional racism / differential treatment / discrimination continues to exist due to race and culture – “Over the years, it has got better, but institutional racism still exists”.
- Overmedication of BME people – “Black people are overly medicated”.
- Lack of culturally sensitive therapy “they have to take the individual’s culture into consideration when providing counselling”.
- Experiences of isolation and torture through restraints in secure units not believed by members of the public.
- Lack of understanding about Black spirituality – “People don’t like us talking about God”
- Black people seen as instigators when trouble breaks out and blamed and punished as a result – “When an altercation occurs between a Black patient and a White patient, the Black patient gets punished, not the White”.
- Lack of communication and interaction between service providers and BME patients resulting in negative approach towards BME service users - “our culture is not understood due to lack of association, they (service providers) isolate themselves from us (patients)”
- BME individuals treated differently due to history between BME and White people.
- BME individuals kept in system longer than white counterparts – “these delays lead to ‘feeling dumped’.

## **Cultural Needs**

An overwhelming majority of the participants, both in the secure units as well as in the community expressed that “our culture is not understood by them” (meaning by non-BME groups). Some further issues included:

- Infrequent provision of ethnic food / no availability of Chinese food. When ethnic food is provided, it is often not authentic – “they used to provide Chinese meals but of poor quality, however, that has stopped in the last 6-9 months, as they don’t provide these any more”, “although we get ethnic food, it is not as often as I would like”.
- Lack of contact for those in secure units with people from similar backgrounds in community “I have no contact with people from my country either on the ward or in the community”.
- Alienation due to language barriers – “other Asians on my ward speak Urdu and I speak another Asian language, so I cannot communicate with them”.
- Need for knowledge of the elderly to be acknowledged and given more importance – “Old values and wisdom should be embraced instead of being allowed to erode”.
- Speaking in own language discouraged and looked upon with suspicion – “when we speak in patwa, they look at us with suspicion”.
- BME males faced more problems than BME females as they are perceived as being more aggressive, violent and dangerous – “Black

women are seen as less threatening than Black men, so they do better than Black men who are stereotyped as aggressive and dangerous”

## **Mental and Physical Health**

The following issues were of significance to the participants and had an impact on both their mental health and physical health:

- Stigma attached to mental illness, not just by members of the public, but by staff in secure units - “there should be more training for staff in conversing with patients and seeing them as humans who should be treated with dignity and respect”.
- Many participants felt that people with mental health problems were viewed as misfits and not treated with dignity and respect. They also felt that there was lack of interest in patients and more importance put instead on procedures – “patients are seen as misfits, not as humans”, “they do not try to build rapport with patients, only write notes and reports”, “there is mass production in hospitals with no personal interest in patients, only in procedures”.
- A number of those interviewed felt that more education and training programs should be made available for service users both within secure settings and in community to improve their lives. Many participants claimed to be bored and felt they were stagnating in the system due to lack of meaningful activities. They felt too that access to college courses and work placements while still in secure settings would help prepare them for eventual discharge in the community – “there is always shortage of staff which prevents adequate involvement in activities”, “I am stuck on the ward most of the time with nothing to do”, “only basic education is provided here, not at higher level”.
- Service users lacked awareness of what services were available for them in the community. They felt that they did not possess the relevant information and/or did not have means of accessing it, which increased their feelings of helplessness and hopelessness.
- Feelings of alienation due to lack of access and communication with community based services while still in secure units.
- Medical model embraced by service providers as the only way of resolving mental health problems. No acknowledgement given to other kinds of interventions that may be just as effective and more culturally appropriate, such as herbal medicine – “medication is a financial monopoly, how are we going to resolve problems just through medication without other kinds of intervention?”
- Lack of provision of equal treatment / equal opportunities for all cultural groups – “differential treatment is there, but I just cope with it”.
- More escorted leave in secure services – at present not always available due to staff shortages, leading to feelings of “being trapped” – “there is always staff shortages”, “there should be more leeway for people who feel incarcerated to be able to go out for cigarettes and fresh air, but that does not happen due to staff shortages”.
- Lack of provision of more activities appropriate to the individual's needs in secure units, e.g. gym, exercise facilities, woodwork, gardening,

- swimming, library service, etc. – “we need more access to workshops to help us gain training for jobs”, “there should be more rehab programs”.
- Lack of support for families making it difficult for them to visit, especially those who had a long way to travel.
  - BME groups overmedicated, misdiagnosed and sectioned more at present. Many felt that secure units were worse than prisons, as in prison one is provided with a release date, whereas in hospitals, one is detained for longer periods. It was felt that long periods of institutionalization lead to feelings of being “dumped and forgotten”, and made it difficult to settle in the community when eventually discharged – “Black people are diagnosed as schizophrenic most of the time”, “they need to get the diagnosis right for Black people”, “people should not be over-medicated”.
  - There was lack of education on mental illness and the negative side-effects of medication – “people don’t understand their own symptoms, so there should be more mental health education for service users”, “doctors should be providing information on the side effects of medication to the patients”.
  - Lack of culturally appropriate emergency assistance outside of office hours.
  - Many people were sent initially to prison before being relocated in hospitals. They felt that while in prison they had not received appropriate services and hence individuals with mental health problems should not be sent to prisons.

Many of the above issues lead to feelings of frustration, helplessness and hopelessness and in turn exacerbated stress, anxiety and depression.

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## **RECOMMENDATIONS FROM ACMHS**

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- More dialogue between service providers and service users may help encourage open mindedness, tolerance and understanding of client needs and cultural and ethnic differences. This understanding will also help in record-keeping in hospitals being more accurate, as it is the staff members who write reports for reviews and tribunals which have a significant impact on the patients’ lives.
- Education in cultural awareness and sensitivity to different ethnic groups for staff in hospitals, prison, Criminal Justice System and schools. Many times, BME people are lumped together and treated as a homogenous group, rather than seen as make up of people from diverse cultures and from different countries.
- Need for preventative services. Factors contributing to offending behaviour (outlined above) need to be considered in the provision of this, such as drugs, breakdown in mental health, isolation / lack of support and financial problems. Support should be more culturally appropriate and should address these issues. This could include housing support, culturally sensitive support for children who are abused, drug awareness and early intervention programs for youths

before they become involved in drugs and gangs, mentoring programs, and assistance with budgeting skills.

- After care assistance to those discharged from institutions especially housing and daily living skills support. The housing should be in decent areas not hostels or deprived areas where there is abundance of drugs and criminal activities.
- Provision of culturally sensitive and holistic counselling and therapy both within and outside of institutions. As indicated above, a majority of participants were found to have had contact with psychiatrists, implying that they were more likely to be treated along the biomedical model. A significantly low proportion of the participants had received psychotherapy or counselling, and fewer still had received culturally sensitive counselling / psychotherapy.
- While institutionalised, more contact would be beneficial with people from their own culture in community. This could be through organizations such as ACMHS, Pakistani Resource Centre, etc. To this end, private sector should be recognised as not just an alternative to, but an important part of service provision and more support given to them.
- There is need for more professionals from BME communities to work in secure units, e.g. nurses, psychologists, psychiatrists, doctors. At present these are predominantly from White ethnic backgrounds.
- Provision of support in the community by individuals who understood cultural issues. This would not only help to prevent offending / re-offending but also increase feelings of safety and security among service users. A large majority of the participants (25%) claimed to have had no support during the time of committing offences.
- Only 6% of the participants received any support from their families at the time of committing offences. Any successful preventative work in future will have to include the families. More support and education will need to be provided to the families of people suffering from mental health problems, so that they in turn can provide support to the individuals concerned.
- More assistance for dependents of people suffering from mental ill health, whether in community or in institutions.
- Research has consistently shown that employment plays a major role in the well being and recovery of people suffering from mental health problems. In addition, a large number of participants identified interest in the provision of more employment and training opportunities. All except one of the participants also expressed employment aspirations, some of which included labourer; painting and decorating; catering; office work; gardening; mentoring for Black youths; personal trainer; plastering; teaching; plumbing, industrial cleaning; electrician; and film-making. Furthermore, all the participants, including those in the community were on benefits, despite the fact that a large majority of them had completed secondary school and some had college or university level education. In view of all this, consideration needs to be given by policy makers to make appropriate work and training opportunities more available and accessible to ex-offenders with mental health problems. This could include improved provision of work

and training programs while in institutions to better equip the individuals for eventual reintegration into society as contributing members, as well as similar support in the community. It will also help enhance the individuals' self esteem and self worth.

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## CONCLUSION

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The survey identified the complexity of the issues involved for BME offenders and ex-offenders with mental health problems. Some of the issues identified by BME participants, such as lack of training / educational opportunities, and lack of outdoor activities, were equally valid for non-BME people.

There was a general lack of trust by the participants, in the system and in any potential enterprises for change. Most of them felt that they had been subjected to the same line of questioning a number of times in the past and that these issues have been identified over and over again in the past, without the benefit of significant changes being made in either institutions or at the community level to resolve those issues.

Many found some of the questions relating to their index offence or nature of their mental health problems very intrusive and either refused or were hesitant to answer them. Others had a difficult time concentrating and answering questions properly possibly due to the effects of medication they were on.

Considering that a large number of them felt that BME people are over-represented in prisons and secure units, overmedicated and misdiagnosed, and kept in the system longer than their White counterparts, perhaps the next step should be to look at these issues from the perspectives of staff members who are involved most in the diagnoses, sectioning and medicating of the BME patient population to see why this is the case. The results of such studies would help us understand the processes involved and in turn lead us to create better and appropriate solutions.

In the meantime, it is important to address at least some of the issues that the participants have identified as causing them distress in order to try and alleviate some of their pain and provide them with the hope that they seem to presently lack.

It is time that we all worked towards making his a more tolerant multi-cultural society. As one of the participants so aptly put it, "We should be allowed to embrace each day in our own ways"

## **Ex Offenders in Community Settings Survey carried out by Sana Riaz on behalf of Pakistani Resource Centre (PRC)**

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### **ABOUT PRC**

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The Pakistani Resource Centre is a charitable organisation that was established in 1966. The Centre provides essential services which reflect the needs of the South Asian communities in the manner which is religiously and culturally sensitive to service users in Greater Manchester.

The Pakistani Resource Centre aims to empower South Asian Communities (those who come from Pakistan, India, Bangladesh and neighbouring countries and follow Islam Hinduism and Sikh faiths) to confront some of the problems they may experience including unemployment, poor housing in inner city areas, racial abuse and cultural alienation. Some of our services include providing counselling, emotional and practical support to individuals experiencing mental ill health, their carers and families. We provide support to victims of domestic violence; we also work in the field of criminal justice. We provide statutory mainstream services and other voluntary organisations with information about South Asian ideas of personhood, culture and belief systems.

The Pakistani Resource Centre aims to empower the South Asian communities to confront some of the problems they may experience. The Centre works in many different ways with BME communities and various projects have specialised roles within the services they provide.

The Black and Asian Offenders Service (formerly known as the South Asian Offenders Project) was established in 1996 and has been working alongside the National Probation Service as a partnership agency ever since. The project comes under the umbrella organisation of the Pakistani Resource Centre. Several other projects also operate from the centre catering for the South Asian community across Greater Manchester.

The service has developed and expanded over the years not only in composition of staff but also in the areas of expertise in regards to culture, religion and ethnicity and how it fits in with the Criminal Justice System. The Service operates throughout the whole of Greater Manchester and our work practice is to visit each individual offender and Offender Manager at the designated Probation Office.

The service is focused upon complementing the work of Offender Managers to ensure that clients from Black and South Asian cultural backgrounds have better access to service provision. The term Black refers to people from African or African-Caribbean background. The term South Asian refers to people of Bangladeshi, Indian, and Pakistani, Sri Lankan and British origin with heritage in one of the above mentioned countries.

The aim of the Black and Asian Offenders Service is to provide consultancy on faith and culture of Black and South Asian Offenders throughout the Greater Manchester area. This is achieved by:

- Providing consultancy to Offender Managers on culture and faith issues for Black and Asian Offenders.
- Co-working and consultancy with Offender Managers on complex cases, providing a cultural and religious perspective to offending throughout all stages of probation intervention.
- Ensuring that Black and South Asian service users have equal access to justice and are not constrained by a lack of understanding of their culture, faith or language or by their own lack of understanding of the criminal justice system.

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## METHODOLOGY

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As Part of the survey, the Pakistani Resource Centre was asked to undertake 30 interviews with Black Minority Ethnic offenders within the community of Greater Manchester. Our focus was on the South Asian communities.

In order to carry out this survey effectively, I approached various projects based at the Pakistani Resource Centre. I managed to get many participants from the Trafford South Asian Mental Health Service by accessing the Men and Women's drop in session which was held on a weekly basis. There are approximately 7-10 men and 8-12 women who attend on regular basis. A brief introduction was given about the aim of the research and participants from this group agreed to take part in one to one interviews. A focus group was also arranged; however they failed to turn up. Intended participants shared at a later date that due to the nature of the research many felt this was an invasion of their privacy to participate in the focus group.

Other participants were accessed through the Welfare Rights Project. Welfare Rights clinics are held on a weekly basis, two in Cheetham Hill and one in Longsight. The survey was introduced to service users to establish whether they had any dealing with Mental Health and the Criminal Justice System. A number of service users were willing to take part in this survey provided it was on a one to one basis. Individual home visits, where arranged to maintain confidentiality.

In order to gain access to more participants, I the 'word of mouth' approach was used and with the service users I came into contact with, if they knew of anyone who is willing to participate in this survey. This was a successful approach and helped to achieve the number of participants needed for this survey.

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## ANALYSIS OF PRC SURVEY

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The questionnaires were fully completed in the community settings. The method used for this was one-to-one interview in various settings such as public places, home visits and drop-ins. For this survey, anecdotal evidence and the qualitative results have been categorised into two sections, 'health and well being' and cultural needs'

### **Cultural needs**

Many participants felt that their cultural needs were not being met. The male participants who had experienced the prison service had very negative attitudes towards the staff. They felt that their cultural needs were being ignored and not fulfilled. Many examples were given on situations by relating to the food and bathroom facilities not being culturally appropriate.

“Need to give Asian food cooked by Asians so it tastes nice

Many participants also felt that they were perceived purely on the basis of their ethnicity being Asians or outcasts within the systems.

“I feel quite different and put on the spot. I don't want to feel different I am only human and so is everyone else. I don't judge anyone so I should not be judged”

Both the males and females felt that the prison service would not permit them to be flexible with allowing them to pray daily 5 times or allow them to read the Qur'an. They felt no understanding was shown for this. Many of the Muslim participants felt in particular, that the prison service should have some type of understanding. Many of the Muslim participants felt that the prison system should have some type of cultural training where their understanding can be brought in to consideration of different cultures and not just the Asian culture alone.

“Sometimes you can't get time or a place to pray. You have to explain your religion and needs to everyone”.

A female participant who had been imprisoned felt that the body search made her exploited and more consideration should be taken into one's modesty.

Many participants who had not experienced the prison service felt that there were not enough services out there that were culturally appropriate for them in the community. Many felt that the services out in the community needed to be improved and increased. They felt that more culturally appropriate staff need to be recruited who can also communicate in the South Asian languages.

The survey findings indicate that the participants' felt that their needs were not being met and this was due to cultural barriers.

“The doctors rely too much on the medical model and do not take into account spiritual therapies.”

Another concern raised within this survey was the lack of awareness of Mental Health within the places of worship. Participants suggested that perhaps the local 'faith leaders' received training on Mental Health issues as many people approach the faith leaders to find remedies for their mental distress. This is due to the fact that many people hold their religion in high prestige and feel that their religious faith will help them in the recovery process.

Many participants had negative attitude towards the criminal justice system, this would include the police, probation, courts and the prison service. They felt that in particular, the police service shows racism and hate towards the South Asian community. One participant gave the example of being arrested and that this was way over the top and over reacted when being arrested in the presence of two police vans and dogs. They also felt lack of cultural knowledge was present and a sense of being spoken down to was also present. This didn't help those participants in particular whose first language was not English.

However they felt that probation was one of the few services that showed cultural understanding and took one's religious needs into consideration. However they did feel that more south Asian staff should be present within these services and have more understanding of cultural and family values.

### **Health and wellbeing**

Many participants felt that they were experiencing feelings of stress and anxiety whilst they had involvement with the criminal justice system. They felt that this did not help what they were feeling and going through.

Many participants had thoughts about committing suicide and felt that they could not go through with it. They felt very low at the time and were not coping with much that was happening at the time of these feelings. Many had put it down to family breakdown.

At present the majority of participants said their physical health was poor with a small amount saying that they were in good health. Whilst the participant were under the mental health care system they also said that their physical health was good. 63% of the participants also felt that at the time of their offence their mental state was not good but now it had improved since they have moved on and got better. It was a general consensus when under the mental health care programme, the standard of care was satisfactory when interviewing.

Many of the offending behaviours resulted from the anxiety and stress that participants were feeling at the time. Many were experiencing family breakdown and financial worries at the time, for some the offending was a cry for help.

20% felt that they did not want to burden family members with their problems and felt very ashamed of sharing this with others. Depression was reported as to be the common mental health illness amongst the south Asian women. Most of them relied on the medication and felt that counselling helped them get through this slowly. There was general consensus with the participants that they were unhappy with the healthcare services and felt that this was down to their South Asian origin and they

were always last to be seen by a medical healthcare professional. However, this appeared to be only their assumption as no evidence was given to back this up. Many women felt strongly about not being seen by a counsellor and stressed the waiting time on that was not appropriate. They felt that they needed someone to talk to i.e. counsellor, and they could benefit from this service if more counsellors were available. This left many participants feeling angry and bitter. This was seen as a contributing factor to them offending and worsening their mental health at the time. This also appeared to affect some participants in different ways such as feelings of isolation, oppressed and negative impact on physical and mental health.

Participants felt that talking to community members was not an easy task for them. Especially when being involved in the criminal justice system and mental health would just send out wrong signals. The south Asian community can have its stereotypes like any other culture or religion. Having been involved with the both services of Mental Health and Criminal Justice System can show signs of weakness and having implied that one is suffering from 'black magic', and the casting of 'evil eye'. This can leave individuals certainly a feeling scared and isolated and can be the trigger for other illness. There is a need to ensure that service users have an understanding of the medical aspect of mental health as well as the cultural aspect of Mental Health i.e. 'evil eye'.

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## **RECOMMENDATIONS FROM PRC**

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Many participants have suggested many recommendations that need to be addressed in various different settings. The recommendations have therefore been separated under different headings as hospitals / secure units, prison service and the Community.

### **Hospitals / secure units**

- More activities in hospitals involving various group therapies and allowing patients to make friends whilst on the ward.
- More awareness raised for BME service users of mental health within the hospitals.
- More culturally specific counsellors are needed now.

### **Prison service**

- Educate more professionals on the mental health needs of Black and Minority Ethnic Offenders.
- Recruit more culturally appropriate staff

### **The Community**

- More culturally appropriate services available that benefit individual communities, i.e. south Asian counsellors.

- Activities taking place during the day and have more evening groups set up self help group.
- More support groups
- More befriending services
- Activities specific for men to do in the community / men's group involving leisure activities.
- More BME services provided that are culturally sensitive for the needs of that particular community.
- The faith leaders to receive training on mental health issues as they are a key contact for service users.

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## **CONCLUSION**

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The purpose of this survey were to establish whether there were appropriate services along the Offender Mental Health Care Pathway,

The perceptions of the participants within the survey highlighted that their culture, race and religion played a significant role in terms of service provision. The participants have suggested that the mainstream services would be more approachable if the staff was given cultural and religious training specifically aimed at the BME communities.

In terms of the community, participants felt that we must raise awareness of Mental Health within the community and its impact on the individuals' lifestyle and the influence on the community in general. This can be essential as this may help eliminate stigma and social isolation in addition to creating a more cohesive community and promoting social inclusion.

Finally, it has been established from the survey that that it would be beneficial to the service users to be offered more support from the commencement to the end of their liaison with the Criminal Justices System and the Mental Health services.

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## THE WAY FORWARD

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This report will now be disseminated through an organised event in April 2008, providing the opportunity for key stakeholders to discuss the recommendations and to review secure commissioning provision for BME Offenders.

During the lifetime of this project it was recognised that training for the workforce in relation to BME Offenders was needed, however this was not achievable within the timescales of the project. From the information gathered at the event and the survey this area will be addressed within an agreed action plan between Secure Commissioning Services and key partnerships.

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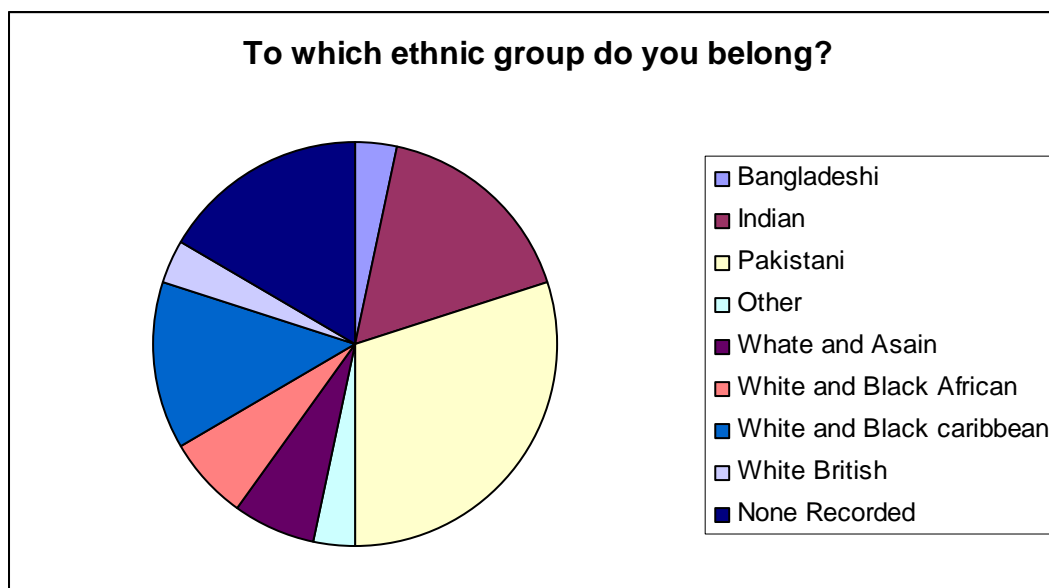
## APPENDIX 1 - BME OFFENDERS IN PRISON

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As indicated previously a questionnaire and focus group took place with 30 ex-offenders incarcerated in the prison system and placed at HMP Haverigg in Cumbria

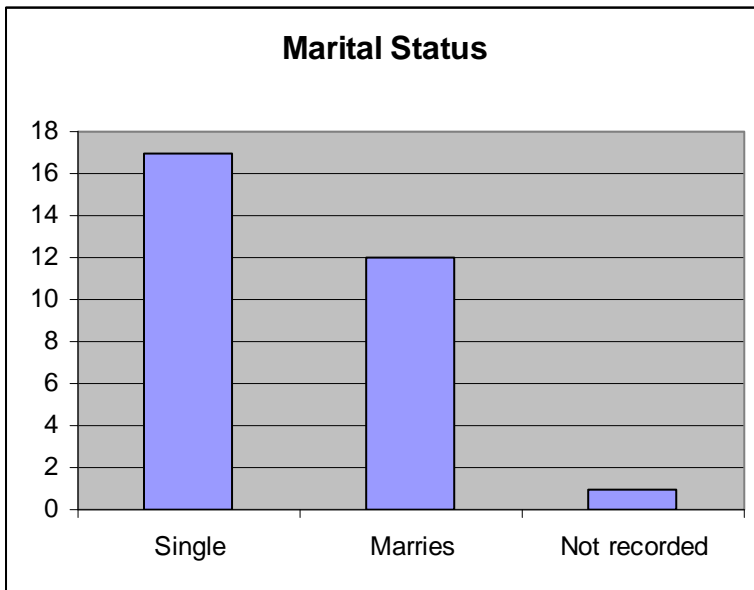
The following is an analysis of the questionnaires

### Ethnicity



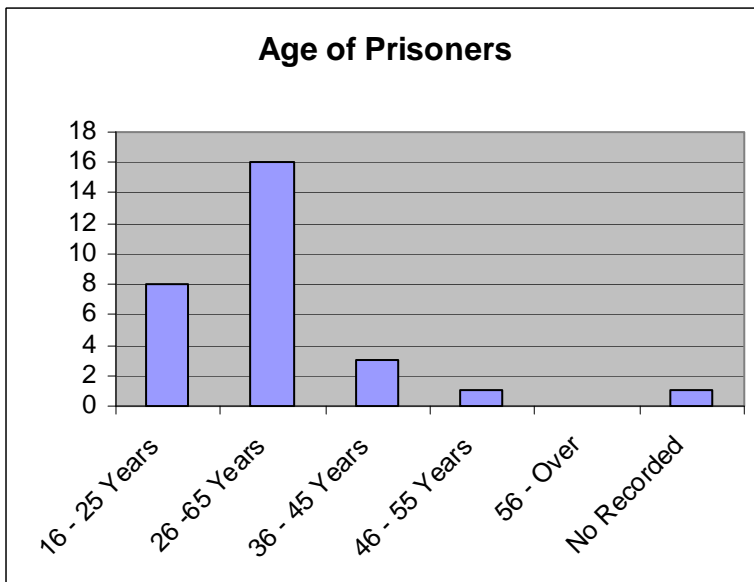
Bangladeshi	1
Indian	5
Pakistani	9
Other	1
White and Asian	2
White and Black African	2
White and Black Caribbean	4
White British	1
None Recorded	5

## Marital Status

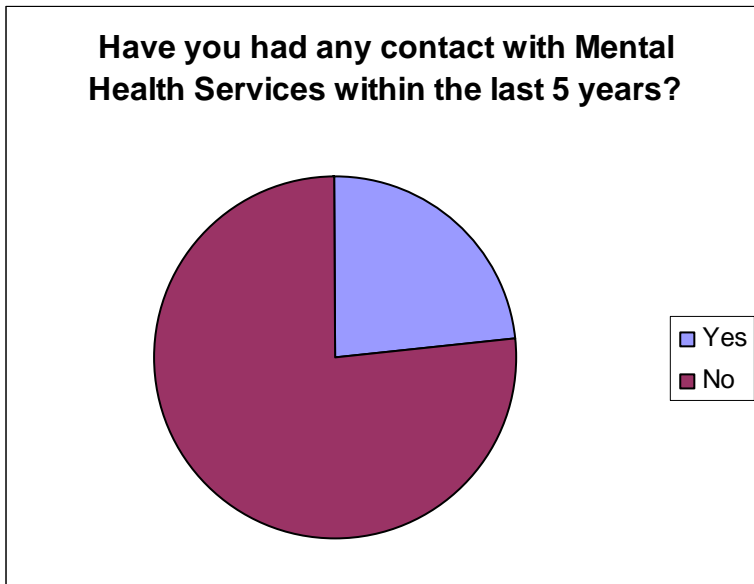


The above graph shows that 17 of them were single, 12 were married and 1 did not provide an answer. The position of their marital status can play significant role in regards to emotional well being as often spouses and support structures can help in alleviating issues experienced by prisoners whilst incarcerated.

## Age



**Have you had any contact with Mental Health Services within the last 5 years?**



A small number (7) of the participants have admitted to have been in contact with a Mental Health Service. They specified the following areas -Community Mental Health Team (1) Psychiatrist (3) and GP (3)

Background Information

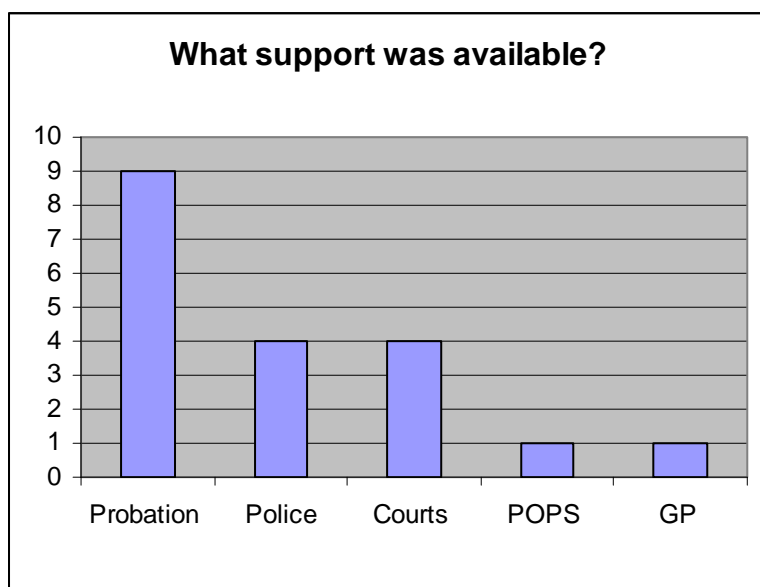
What was the nature of the offence(s)?

The majority of the offences registered by the prisoners were drug related.

What contributed to your offending?

- Choice
- Money
- Drugs / Alcohol
- Broken home
- Breakdown of marriage

## During this time what support was available?



### Services and Support

Have you had any contact with general care services?

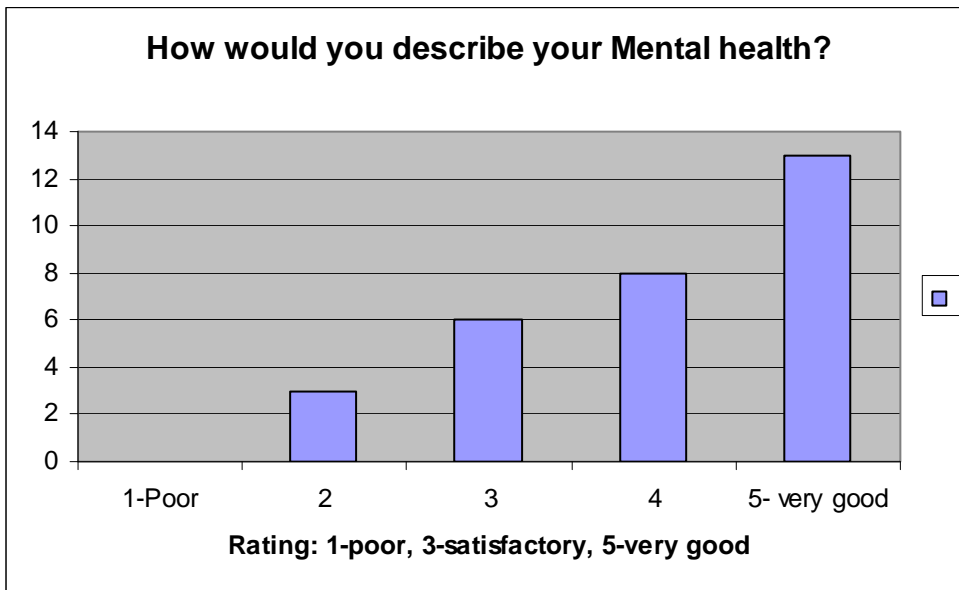
Here fourteen of the participants have had contact with the general care service and fourteen of them have had no contact with the general care service. One individual did not provide an answer. Out of the fourteen that had been in touch with the general care service two of them were mental health issue related.

“I was on anti-depressants when I got released after serving 23 months, but when I got recalled, I stopped taking them as I was only depressed outside”

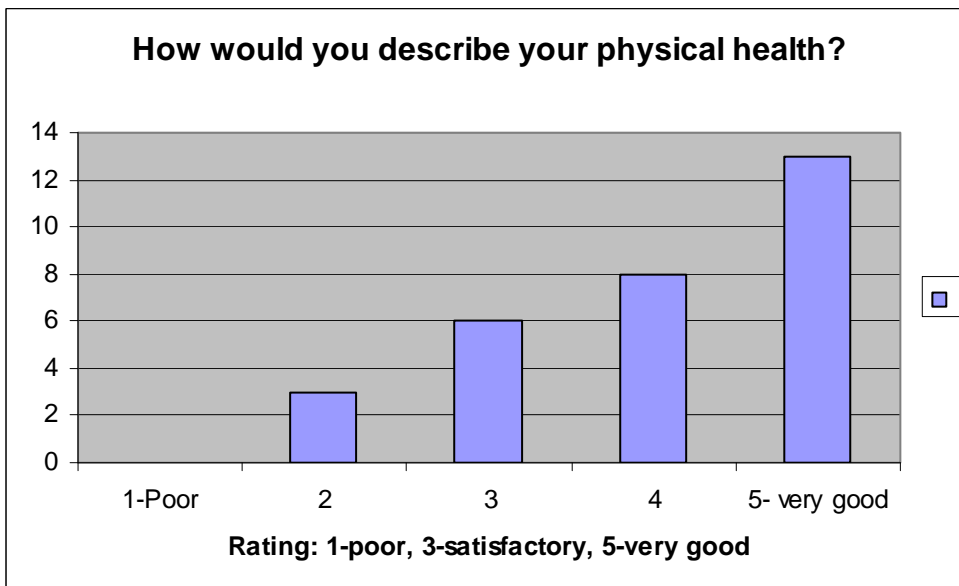
### Culture

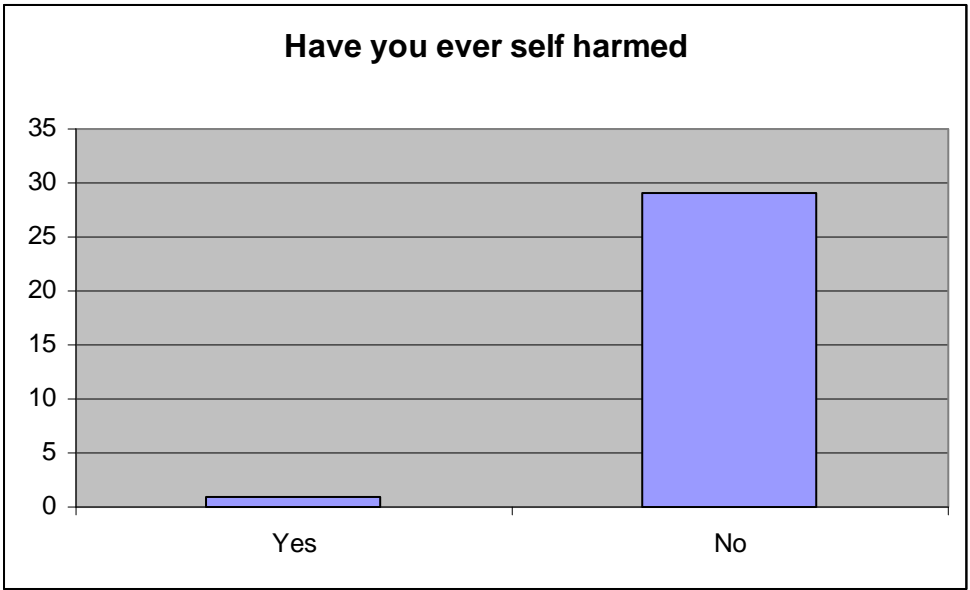
The vast majority of the participants expressed some dissatisfaction with the prison service. They felt that prison officers in the main lack understanding of the prisoners' cultural needs in relation to faith, beliefs, food and the differences between people from differing communities and races. Many of them felt this problem results in frustration and can lead them to a depressive state.

## Well being and your Needs

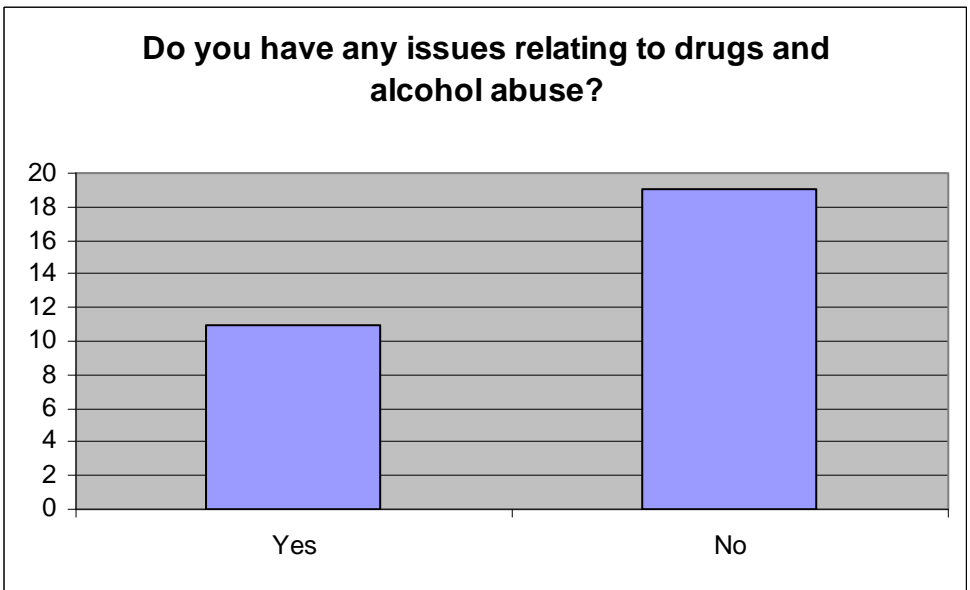


The majority of the participants described their mental health as very good. However, on further discussion it transpired that they had very little knowledge of what actually constituted as a mental health issue.





Only one participant admitted to self harm, he subsequently received medical attention.



A large number (36.6%) of the participants admitted to issues relating to drugs and alcohol abuse.

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## APPENDIX 2 – ANALYSIS OF OFFENDERS IN SECURE UNITS

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A total of 30 BME participants were interviewed. These included 14 individuals in the community (11 in one to one interviews and 3 in a focus group) and 16 individuals residing in secure units.

The 16 participants in secure units included the following:

Bigfoot Independent Hospital: 2 participants.

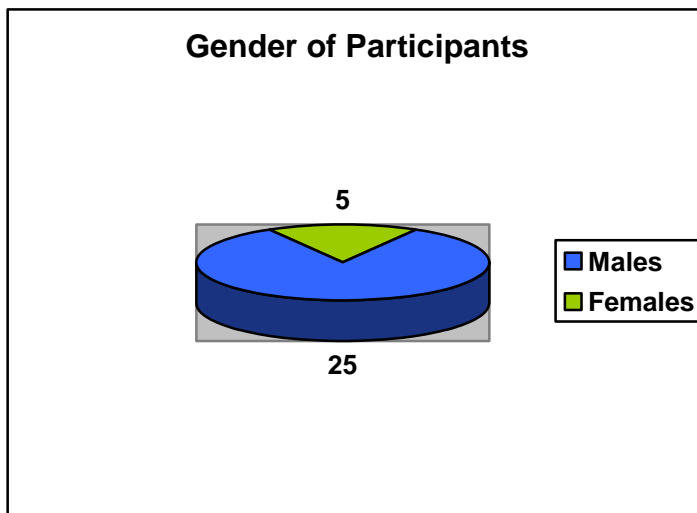
Jigsaw Independent Hospital: 2 participants.

The Spinney: 2 participants.

Edenfield Unit: 10 participants.

Key findings were as follows:

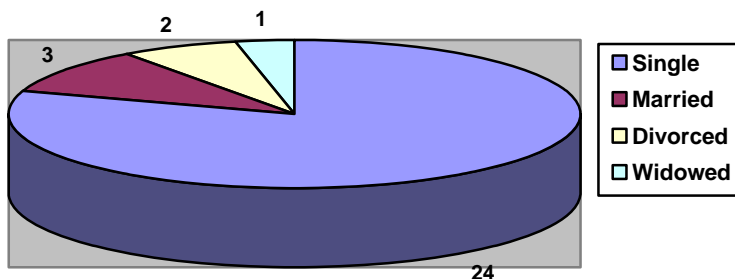
### Gender



A total of 25 males and 5 females were interviewed. The reason for the gender bias can be attributed to the fact that there were more male BME patients in the secure units compared to female BME patients (only 1 female BME patient was identified by staff members for this survey). Furthermore, both the Spinney and Bigfoot are hospitals catering to male patients only.

## Marital Status

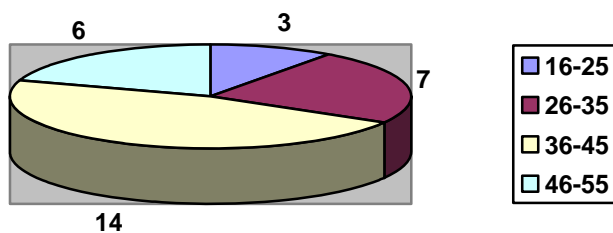
### Marital Status of Participants



The majority of participants interviewed were single (24). Only 3 were married, 2 divorced, and 1 widowed. This may be explained by the fact that most of them had severe and enduring mental health problems, which may prevent the individuals from forming long-term relationships and/or maintaining relationships over a long period. A further explanation could be that many of the individuals who were in secure units had been in institutions (either secure units and/or prisons) over a long period of time and hence been unable to form any lasting relationships. This may be the case too for the participants who were presently in the community, as some of them had spent long periods in secure units and/or prisons prior to being released into the community. Further research needs to be conducted to explore the reasons for this relationship.

## Age Range

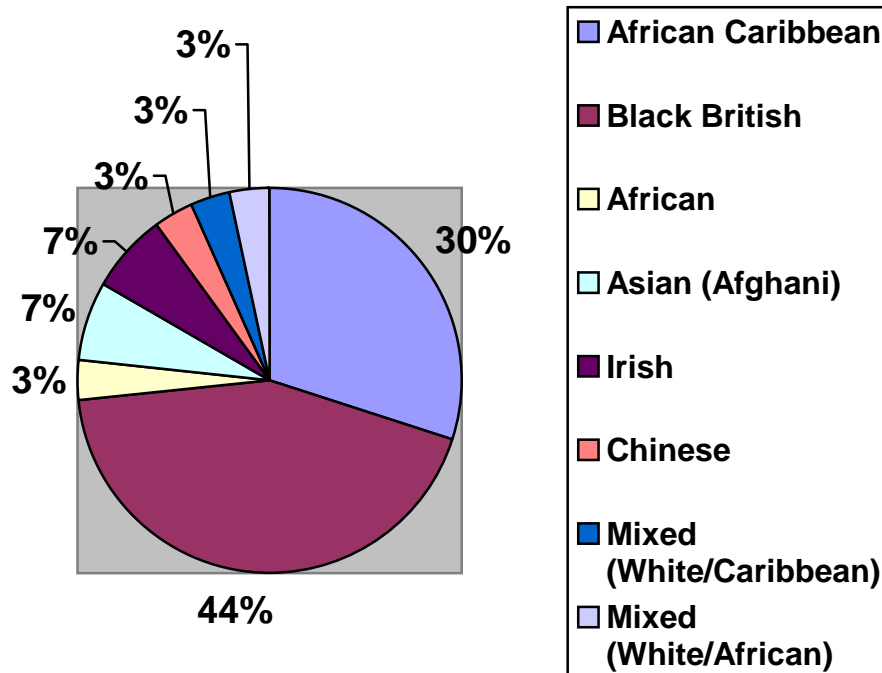
### Age Range of Participants



The majority of the participants (14) fell in the age range 36-45 years. 3 were in the age range 16-25 years, 7 in the age range 26-35 years, and 6 in the age range 46-55 years.

## Ethnicity

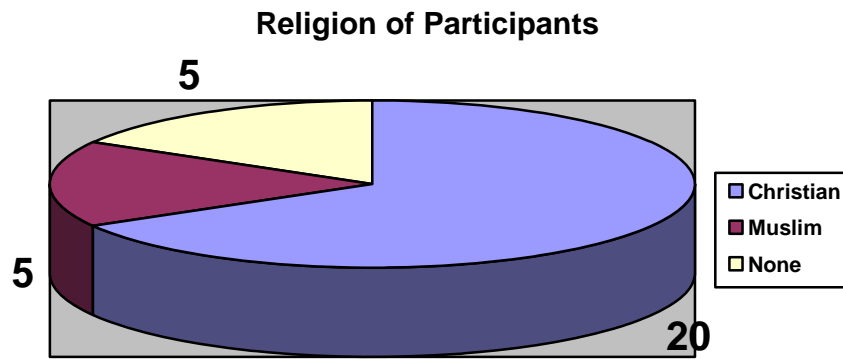
### Ethnicity of Participants



Participants were from various ethnic groups and included the following:

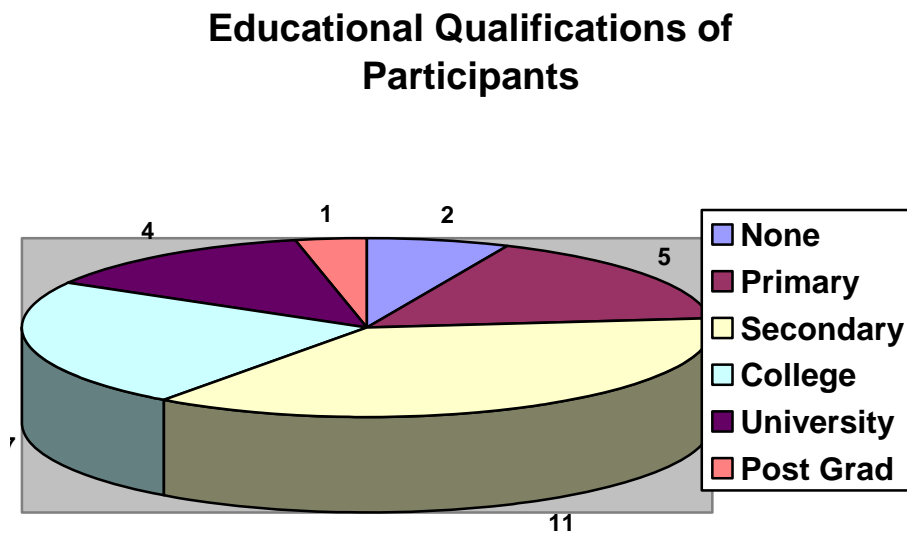
Black British	13 (44%)
African Caribbean	9 (30%)
African	1 (3%)
Asian (Afghani)	2 (7%)
Irish	2 (7%)
Chinese	1 (3%)
Mixed: White / Caribbean	1 (3%)
Mixed: White / African	1 (3%)

## Religion



The majority (20) of the participants were Christians, with 5 Muslims and 5 following no particular religion.

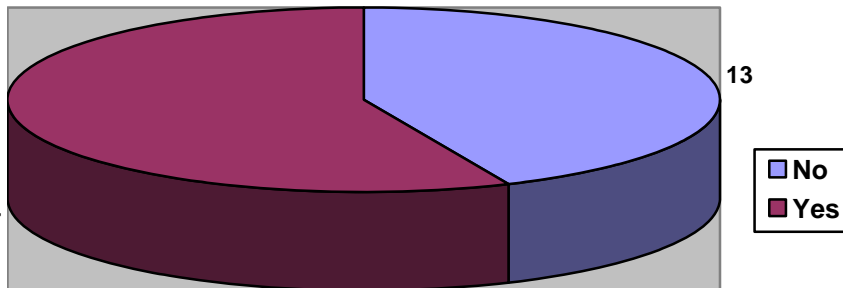
## Level of Education



The majority of participants (11) had completed secondary school education, with 7 having completed college, 4 having completed university and 1 having post graduate qualifications. Two of the participants had received no formal education.

## Contact with Criminal Justice System in the Last 5 Years

### Participant's Contact with CJS

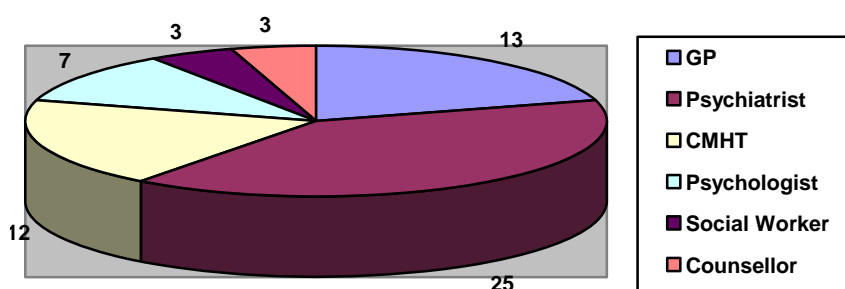


Of the 30 participants, 17 had been in contact with the criminal justice system in the last 5 years. Of these 10 claimed to have been in prison. This could be attributed in part to the fact that many participants in the secure units had been there for over five years.

## Contact with Mental Health Services within the last 5 years

All 30 participants claimed to have had contact with the mental health services in the last 5 years.

### Type of Contact with MH Services



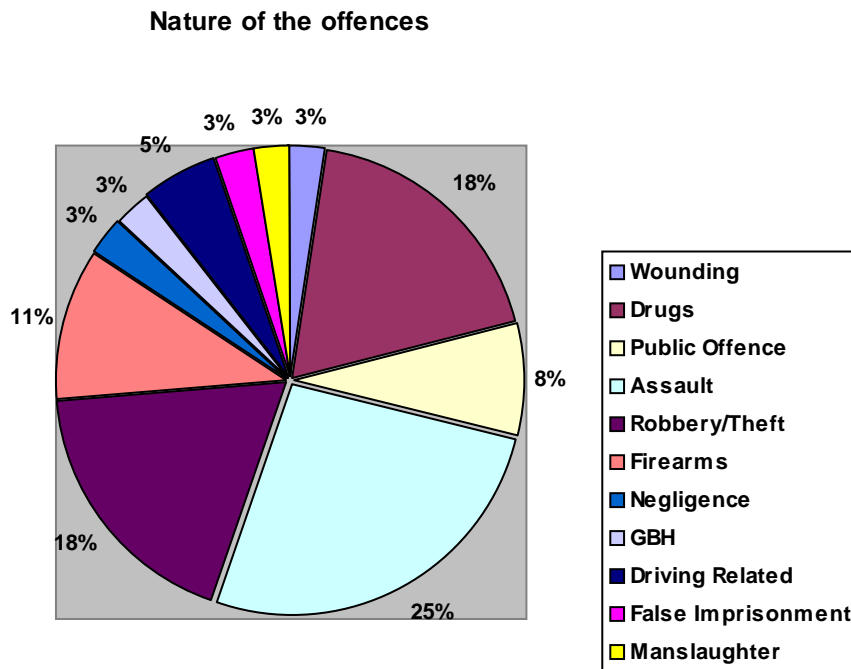
Of these, the majority (25 participants) had contact with psychiatrists, implying that they were being provided with biomedical treatment. Compared to this number, only 7 had had contact with a psychologist and 3 with counsellors indicating that a significantly low proportion had received some form of talking therapies. 13 participants claimed to have had contact with their GP, 12 with the Community Mental Health Team and 3 with social workers. The majority refused to state why

they had seen any of these professionals, and claimed to find the question very personal and intrusive.

## Background Information

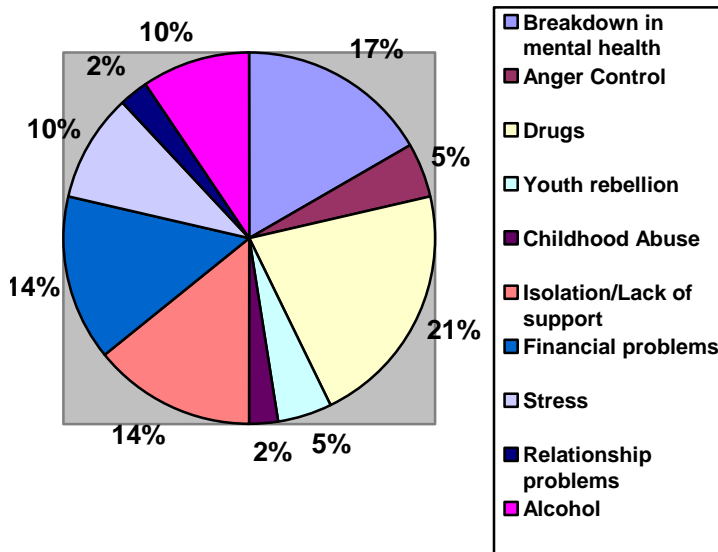
### **Convictions**

All except one participant claimed to have been convicted of a crime.



The majority of the offences registered by the participants were assault (10 participants), followed by robbery / theft (7 participants), and drugs (7 participants). 4 participants stated firearms and 3 mentioned public offences. However, it was noted again that the participants found this question very intrusive and were hesitant to provide responses. Hence, the above may not be a true reflection of the offences committed.

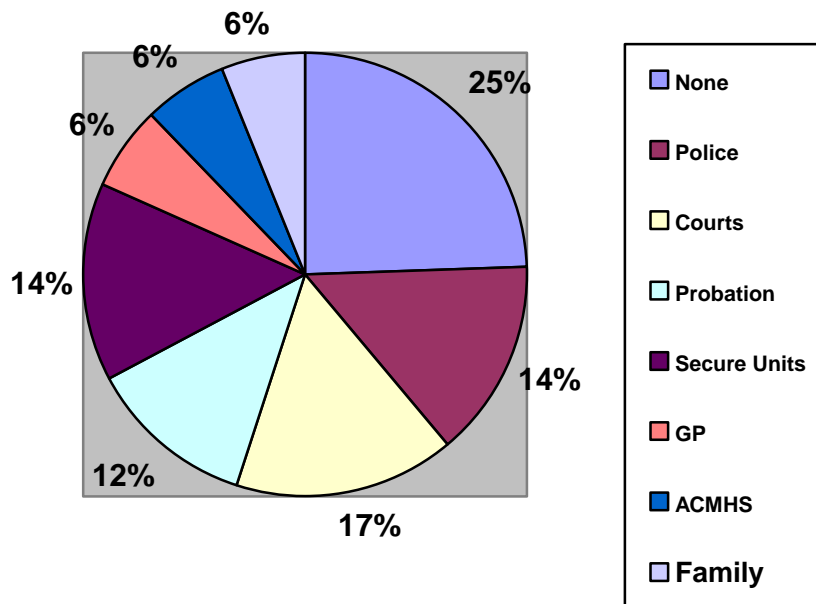
## Factors contributing to the offending behaviour



Various factors were cited as contributing to the offending behaviour. The main one being drugs (cited by 9 participants), followed by breakdown in mental health (cited by 7 participants), isolation / lack of support (cited by 6 participants) and financial problems (cited by 6 participants). These findings have major implications in preventative work and are issues that need to be addressed by the relevant authorities. They will be discussed further in the recommendation section.

## Support available during this time

### Support available to participants



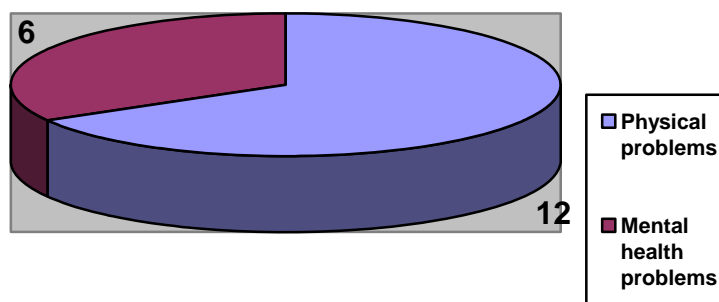
A large majority (12 participants or 25% of the total) claimed to have had no support during the time of committing offences. 8 (17%) of the participants claimed to have received support from the courts, and 7 (14%) each from the police and secure units. 6 (12%) participants claimed to have received support from probation. Only 3 (6%) participants claimed to have received any support from their families. Again, this has major implications in preventative work, and if successful positive outcomes are to be achieved, then more support and education needs to be provided to the families of people suffering from mental health problems, so that they in turn can provide support to the individuals.

### Services and Support

#### **Contact with the General Health Care Services**

Fourteen of the participants had not had any contact with the general care service, while 16 claimed to have had contact.

**Reason for contact with General Health Care Services**



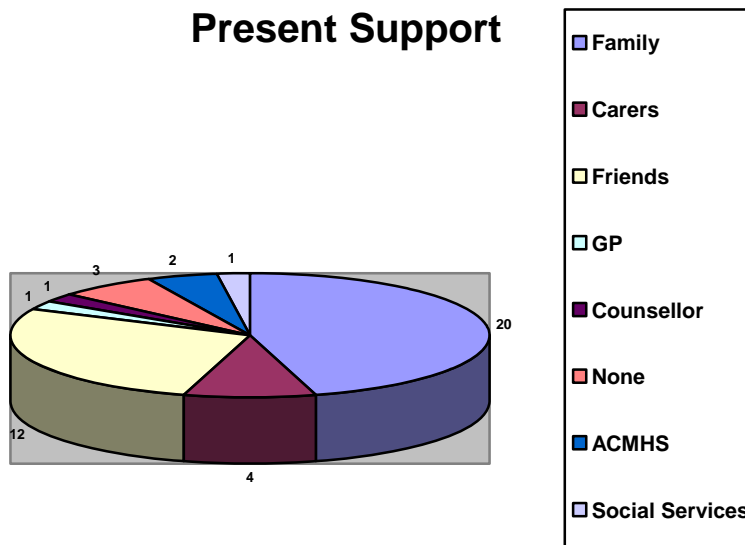
The main reason for contact with the general health care service was physical ailments.

#### **Barriers to Practicing Faith**

Only 1 participant felt that there were barriers to practicing his faith as there was no Imam available in the secure unit.

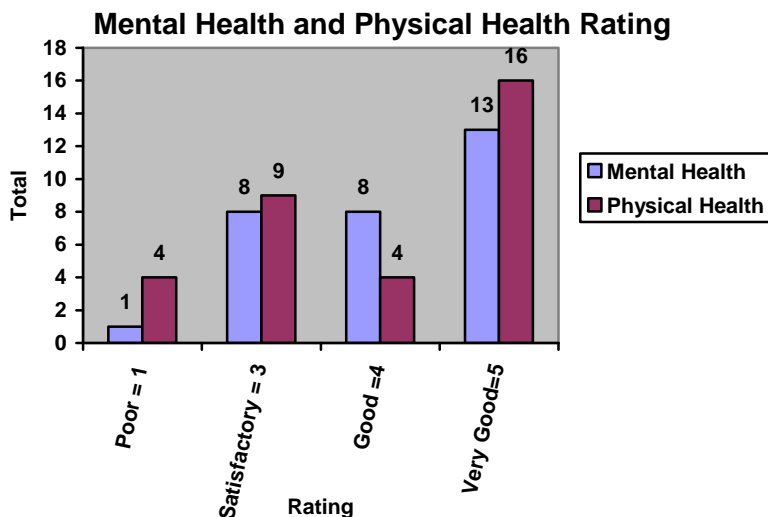
The rest of the 29 participants were satisfied and felt no barriers existed in this regard.

## The Support



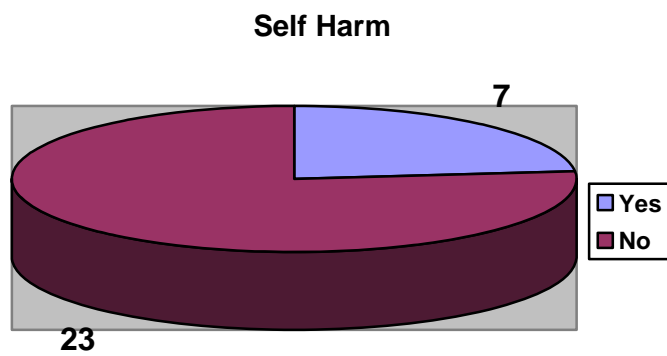
A large majority of the participants received support in the form of visits and telephone calls from family and friends. However, most of the families did not receive any help or support themselves. This is an area that needs to be investigated through further research.

## Well being and Needs



The majority of the participants (including the ones in secure settings) rated their mental health and physical health as being either very good or satisfactory. This may be attributed to the fact that most of them considered mental illness to be stigmatised in our society and believed that people with mental health problems were treated as outcasts by society. Those holding such beliefs are likely to deny having mental health problems despite visibly suffering from them. Again, more research needs to be conducted to explore this point.

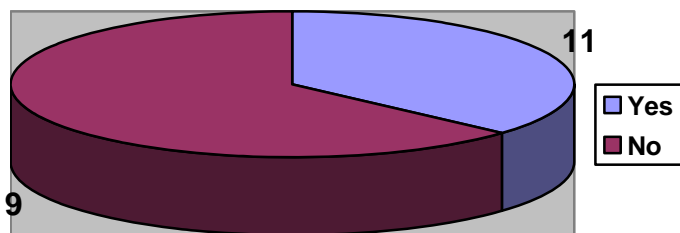
## Self Harm



7 participants claimed to have self-harmed. Of these, 5 maintained that they had received treatment and 2 asserted that they had not received any treatment.

## Drug and Alcohol Abuse

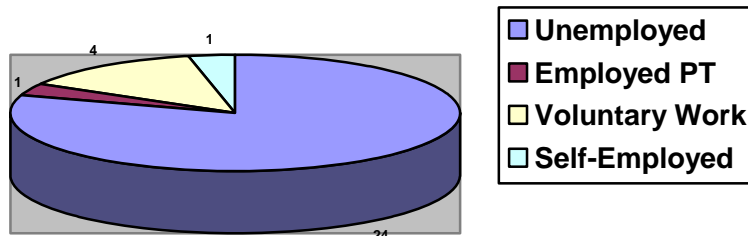
### Drug and Alcohol Abuse



Of a total of 30 participants, 11 claimed to have abused drugs and/or alcohol. In the absence of more detailed information on the individuals, it is difficult to ascertain whether these figures are a true representation of the extent of the problem or whether they are an underestimate of the real magnitude of the problem. This is because it is difficult for people to admit to drug or alcohol use, especially in a research project, to someone they are unfamiliar with.

## Employment Status

### Employment Status



Of the total of 30 participants, 24 were unemployed. 1 was employed part-time, 1 was self-employed, and the other 4 were involved in voluntary work.

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## APPENDIX 2A

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My name is Maya Simmons and I work for the African and Caribbean Mental Health Services. I have been commissioned by the Care Services Improvement Partnership North West to conduct a survey to identify the mental health needs of Black and Minority Ethnic Offenders in secure hospital settings.

The aim of this project is to support black and minority ethnic service users and to look at developing appropriate services along the offender mental health care pathway. We are looking to address and identify gaps in service provision for the offender population with mental health needs being a priority.

I would like to request your participation in this survey. It will take around 30 – 45 minutes of your time and will involve you answering some questions about your experiences as a service user.

All answers given by you will be treated in complete confidence and will not be shared with hospital staff. However if you do share something that would seriously put you or others at risk then I will have to share this information. Any information you provide will only be used for the purpose of this survey.

You will not be asked to provide any personal identifying data. You will be free to end the interview at any time without it affecting your present treatment in any way.

The survey will be completed in March 2008. A final report will be produced, which will be made available to anyone who wishes to access it.

A launch event will take place in April 2008 and we would welcome any contributions from respondents who would like to take part in the event and share their experiences.

I hope you agree to participate in this survey and look forward to meeting with you.

Maya Simmons

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## APPENDIX 2B

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My name is Maya Simmons and I work for the African and Caribbean Mental Health Services. I have been commissioned by the Care Services Improvement Partnership North West to conduct a survey to identify the mental health needs of Black and Minority Ethnic Offenders in the community setting.

The aim of this project is to support black and minority ethnic service users and to look at developing appropriate services along the offender mental health care pathway. We are looking to address and identify gaps in service provision for the offender population with mental health needs being a priority.

I would like to request your participation in this survey. It will take around 30 – 45 minutes of your time and will involve you answering some questions about your experiences as a service user.

All answers given by you will be treated in complete confidence. However if you do share something that would seriously put you or others at risk then I will have to share this information. Any information you provide will only be used for the purpose of this survey.

You will not be asked to provide any personal identifying data. You will be free to end the interview at any time without it affecting your present treatment in any way.

The survey will be completed in March 2008. A final report will be produced, which will be made available to anyone who wishes to access it.

A launch event will take place in April 2008 and we would welcome any contributions from respondents who would like to take part in the event and share their experiences.

I hope you agree to participate in this survey.

Maya Simmons

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**APPENDIX 2C**

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Care Services Improvement Partnership 

North West  
Development Centre

SURVEY OF OFFENDERS

CONSENT FORM

I hereby give my consent to be interviewed for the purpose of this survey. I have read the guidance sheet explaining the aims and objectives of the project and the use of the information I provide.

I am free to withdraw from this interview at any time should I wish to do so. All information I provide will be held in confidence.

Signed (Initials only) \_\_\_\_\_

Witness: ----- Maya Simmons

Date: \_\_\_\_\_

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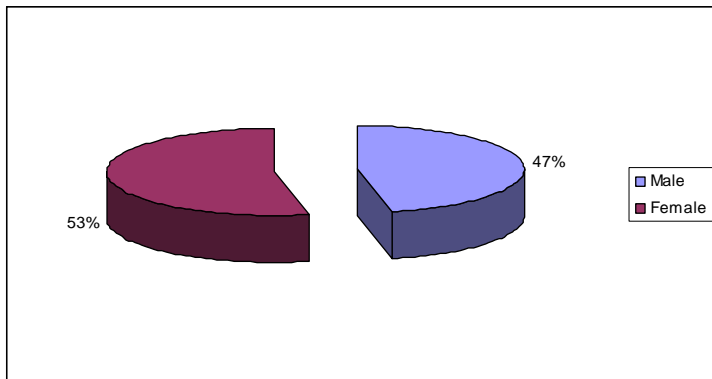
## APPENDIX 3 – EX-OFFENDERS IN COMMUNITY SETTINGS

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The findings from the research are a result of the one to one interviews taken place with both males and females who have been in contact with Mental Health and the Criminal Justice system.

The findings are as follows:

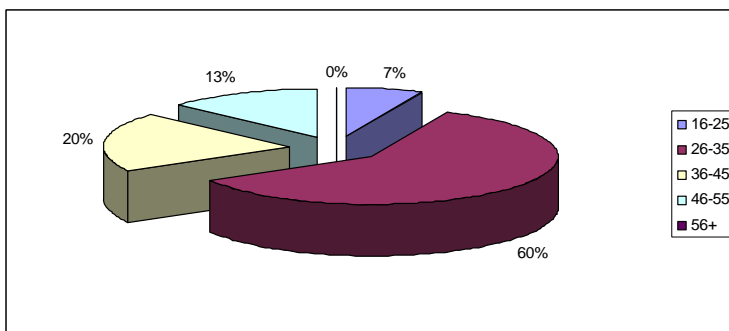
### Are you male or female?



Males	14
Females	16

14 males and 16 females agreed to take part in this survey. More females were willing to take part and admitted to having involvement with the Mental Health system and the Criminal Justice system.

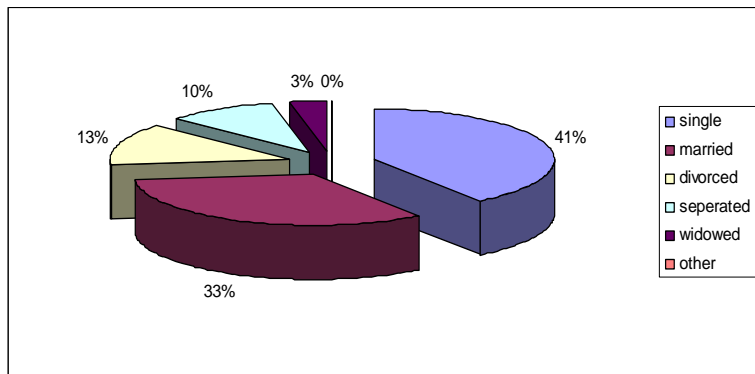
### How old are you?



16-25	2
26-35	18
36-45	6
46-55	4
56+	0

The pie chart demonstrates that a large number of participants fell in to the age category of 26-35 years. This was 60% of the total of participants including both males and females.

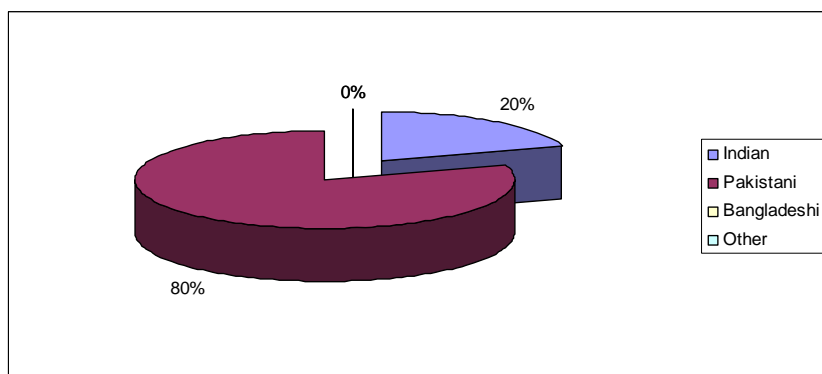
## Marital status?



Single	12
Married	10
Divorced	4
Separated	3
Widowed	1
Other	0

The pie chart demonstrates that the majority of participants were single. , however 10 out of the 30 participants were married this was a lot. Many participants were not living with their partners and would not class themselves as separated but still married as they were not divorced. This can simply explained by the fact that the south Asian culture still does not accept divorce which is still frowned upon. Many of the participants shared that they have moved on from their experience and have now settled in to a stable life.

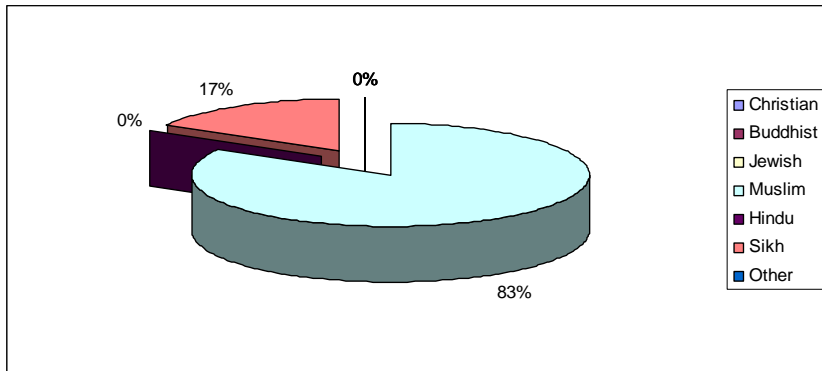
## To which of these ethnic groups would you say you belong to?



Indian	6
Pakistani	24
Bangladeshi	0
Other	0

The majority of participants who took part in the survey were of the Pakistani origin and very few from the Indian origin. The Bangladeshi community is a very tight knitted community and no one wanted to come forward and participate in the survey as the lack of trust with anyone from outside there community played a significant part in this.

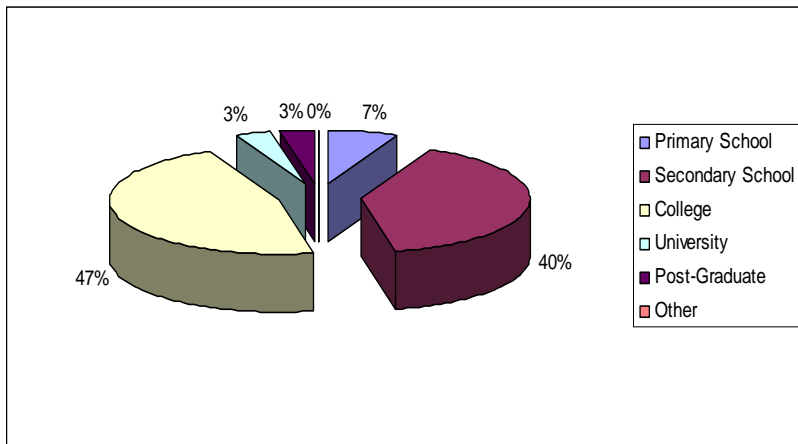
### What is your religion?



Christian	0
Buddhist	0
Jewish	0
Muslim	25
Hindu	0
Sikh	5
Other	0

From the pie chart above this indicates that a high number of participants were of the Muslim faith and only small number of 5 respondents was of the Sikh faith.

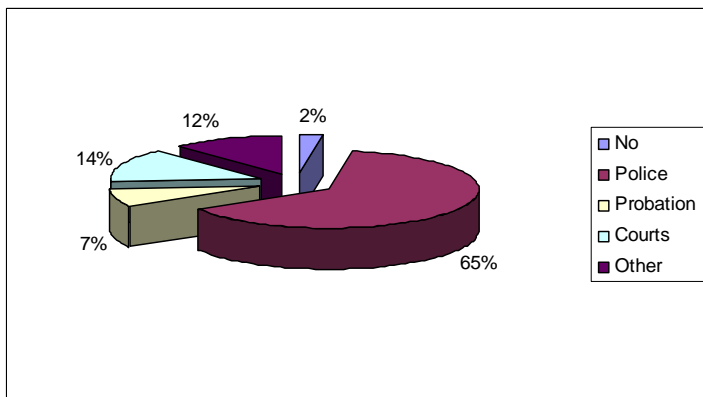
### Highest level of education received?



Primary School	2
Secondary School	12
College	14
University	1
Post-Graduate	1
Other	0

28 out of 30 participants have been in education up until secondary school and 16 out of 30 participants have continued into further education, with the majority going on to college. Only 2 out of the 30 participants have then continued into higher education

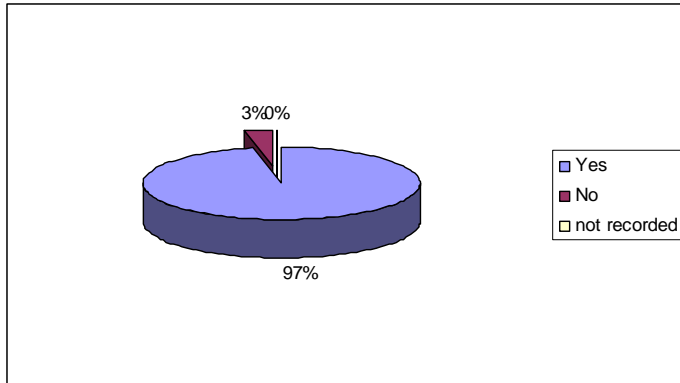
### Have you had any contact with the criminal justice system within the last 5 years?



No	1
Police	27
Probation	3
Courts	6
Other	5

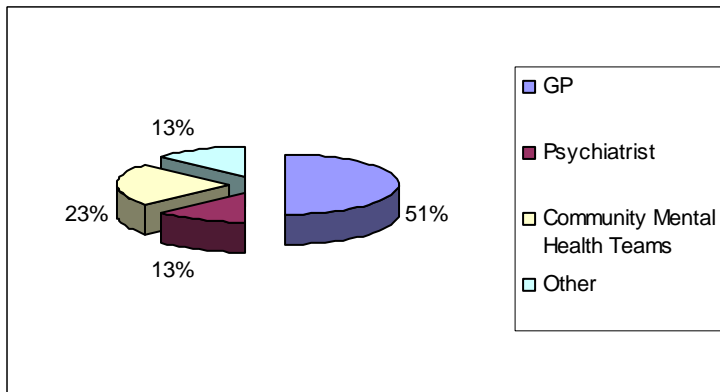
Only one participant out of the 30 had answered they had no contact with the criminal justice system. All the remaining 29 participants have had more than one contact with the criminal justice system. The majority have all had contact with the police. When asked this question 5 respondents had answered other. When asked to specify what other would be all had answered the prison.

**Have you had any contact with Mental Health Services within the last 5 years?**



Yes	28
No	1
Not Recorded	1

**Have you had any contact with Mental Health Services within the last 5 years?**



More than half of the participants had contact with the GP and many other mental health services. The other category fell under different agencies such as

- Drugs team
- Anger management
- Community Psychiatric Nurse (CPN)
- Counsellor

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**APPENDIX 4 - QUESTIONNAIRE**

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## About You

Postcode

**Are you male or female?**

Male  Female

**Marital status**

Single  Married  Divorced  Widowed  Separated  Other

**How old are you?**

16-25 years  26-35 years  36-45 years  46-55 years  56 years or older

**To which of these ethnic groups would you say you belong? (Tick ONE only)**

a. WHITE

British  Irish

Any other White background

(Please write in box)

b. MIXED

White and Black Caribbean  White and Black African  White and Asian

Any other mixed background

(Please write in box)

c. ASIAN OR ASIAN BRITISH

Indian  Pakistani  Bangladeshi

Any other Asian background

(Please write in box)

d. BLACK OR BLACK BRITISH

Caribbean

Any other Black background

(Please write in box)

e. CHINESE OR OTHER ETHNIC GROUP

Chinese

Any other ethnic group

(Please write in box)

**What is your religion?**

Christian (including Church of England, Catholic, Protestant and all other Christian denominations)

Buddhist  Jewish  Hindu  Muslim  Sikh  None

**Highest level of education received?**

Primary School  Secondary School  College

University  Post-Graduate

Other, please specify  \_\_\_\_\_

**Have you had any contact with criminal justice system within the last 5 years?  
If yes, who with?**

No  Police  Probation  Courts  Other, please specify  \_\_\_\_\_

**Have you had any contact with Mental Health Services within the last 5 years?**

Yes  No

If yes, specify what and state why?

GP  Psychiatrist  Community Mental Health Team

Other, please specify

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BACKGROUND INFORMATION

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Have you ever been convicted of a crime? Yes  No

What was the nature of your offence(s)?

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What contributed to your offending?

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During this time what support was available?

Police	<input type="checkbox"/>	GP	<input type="checkbox"/>	Courts	<input type="checkbox"/>
African and Caribbean MH Service	<input type="checkbox"/>		<input type="checkbox"/>	Probation	<input type="checkbox"/>
Pakistani Resource Centre	<input type="checkbox"/>		<input type="checkbox"/>	Secure Units	<input type="checkbox"/>
Partners of Prisoners (POPS)	<input type="checkbox"/>		<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Other	<input type="checkbox"/>		<input type="checkbox"/>		

Please specify other(s) \_\_\_\_\_

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SERVICES AND SUPPORT

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**The Services**

Have you had any contact with general health care services? Yes  No

If yes, please state what and why?

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**What support do you currently have and how would you rate it?  
(Rating: 1-poor, 3-satisfactory, 5-very good)**

	1	2	3	4	5	N/A	
Police		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Courts		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Probation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secure Units		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
African & Caribbean Mental Health Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pakistani Resource Centre		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partners of Prisoners (POPS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Community Mental Health Team		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If other, please specify \_\_\_\_\_

**Do you think your cultural needs are being met? Yes  No**   
Please give details.

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**Are there any barriers to you practicing your faith? Yes  No**   
Please give details.

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**Do you think your spiritual/religious needs are being met? Yes  No**   
Please give details.

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**Do you think your ethnicity forms a barrier to receiving services? Yes  No**   
Please give details.

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**How do you feel you are viewed by service providers relating to your ethnicity?**

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Do you think this has had an impact on how you are treated? Yes  No   
Please give details.

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Have you ever felt unsafe as a result of bullying behaviour? Yes  No   
If yes, please give details.

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Do you think the bullying behaviour was due to your ethnicity? Yes  No   
Please give details.

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THE SUPPORT

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Do your family and/or friends know you are unwell? Yes  No  N/A

Who provides support for you?

Family  Carers  Friends  Other

If other, please specify. \_\_\_\_\_

What support do you receive from them?

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Are they kept informed of your progress? Yes  No  N/A   
If yes, in what way?

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Do they receive assistance in providing support for you? Yes  No   
If yes, please give details.

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**IMPROVEMENTS**

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**How much do you think services can be improved?**

- Cannot be improved**
- Can be improved a little**
- Can be improved a lot**

**What are your suggestions for improvement?**

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**What other services would you like to be made available?**

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**YOUR WELLBEING AND YOUR NEEDS**

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**How would you describe your mental health?**  
(Rating: 1-poor, 3-satisfactory, 5- very good)

- 1**     **2**     **3**     **4**     **5**

**How would you describe your physical health?**  
(Rating: 1-poor, 3-satisfactory, 5-very good)

- 1**     **2**     **3**     **4**     **5**

**Have you ever self harmed?**                      **Yes**                       **No**

**If yes, did you receive treatment?**                      **Yes**                       **No**                       **N/A**

**Have you any issues relating to drugs and alcohol abuse?** **Yes**                       **No**

If yes, what are your issues?

- Disclosure to others
- Previous history of drug and alcohol abuse
- Controlling drinking / drinking to excess
- Problems with prescribed drugs
- Problems with none prescribed drugs
- Other

If other, please specify. \_\_\_\_\_

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THE COMMUNITY

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Are you currently:

- Employed Full time
- Employed Part time
- Working Voluntary
- Unemployed
- Looking for work
- Other

If other, please specify. \_\_\_\_\_

Do you enjoy your work?    Yes     No     N/A

What are your employment aspirations?

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Do you have the skills you require?    Yes     No   
If no, what would assist you to gain the skills you require?

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Do you have any housing issues?    Yes     No   
If yes, please give details.

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Has anyone offered you housing support?    Yes     No   
If yes, please give details.

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**How are you financially supported?**

- Employment**
- Benefits**
- Family**
- Other, Please specify**  \_\_\_\_\_

**Do you have any concerns about your finances? Yes  No**   
**If yes, please give details.**

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**Do you provide financial support to your family? Yes  No**

**Do you need assistance in providing support to your family? Yes  No**   
**If yes, please give details.**

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## APPENDIX 5 – PROJECT INITIATION DOCUMENT

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June 4<sup>th</sup> 2007

### 1. Background

The Delivering Race Equality Action Plan 2005 clearly sets out in its vision for mental health the need to reduce the proportion of prisoners from BME communities. Within the North West the implementation of the plan has initially been targeted within the Greater Manchester Focused Implementation Site. As part of this work the need to address gaps in service provision for the offender population with mental health needs is a priority. North West Secure Commissioning Services and CSIP North West have agreed to work in partnership with the third sector and black and minority ethnic communities. The work will form part of the Greater Manchester Strategic Plan for Secure and Forensic Mental Health services with the primary aim of returning black and minority ethnic service users from out of the area to appropriate secure mental health services.

A needs assessment of demand for low and medium secure mental health services undertaken by Doctor Tony Ryan in 2006 for the North West identified a high number of Black and Black British Caribbean service users. In the North West demand for services associated with psychotic illness in prisons is set to rise over the period 2005-2011 from 502 to 558-590, which will clearly have an impact on growth in demand for secure mental health services. Combined with the increase in prison in reach services which has led to an increase in the early identification of those who require treatment within secure services. Another added pressure is the requirement to ensure transfer of prisoners within target timescales of those who require urgent treatment as a result of mental ill health which will contribute to further growth.

### 2. Project Definition

The project will involve a working group including, North West Secure Commissioning services, CSIP North West, the Third Sector, representation from the black and minority ethnic community. An initial meeting will be held to discuss the draft project plan, make appropriate amendments and to approve it.

The focus of the working group will be to ensure the smooth co-ordination, governance and accountability for the project.

Each of the partners will agree working arrangements to implement the project over an agreed period of six months.

### **3. Project Aims**

The partnership will:

#### **Core Aims**

- To assist North West Secure Commissioning Services in the development of service specifications that meet the needs of BME service users.
- To work with key stakeholders to support the evaluation process of expressions of interest and tenders.
- Creating value and engagement through consultation with both the black and minority offender community and the local community
- To improve and strengthen partnerships with secure providers to provide appropriate integrated services for BME service users.
- Assess the training needs of staff working in inpatient secure settings, offer guidance on required competencies of the workforce and support, to deliver appropriate services when working between the prison and community settings
- Develop and disseminate good practice in relation to the offender care pathway / transitions
- Race Impact and Health and Wellbeing Impact assessments of the needs of the Black and Minority Ethnic offenders

#### **Other Aims**

- Identify the numbers of service users within the prison population who are treated out of the area who require low, medium and high secure mental health services.
- Monitor the existing arrangements in place to ensure that black and minority ethnic service users are offered appropriate and responsive care within the health and social care criminal justice system
- Support the integration of service users within the wider community that exists in secure mental health services
- To reduce the population of black and minority ethnic service users within prisons
- To build on this partnership to support other potential work to tackle the social exclusion encountered by black and minority offenders in returning to the community and accessing employment or further education. Making appropriate links with the North West Reducing Re-offending Action Plan.
- To improve local policymaking, practice and governance in relation to the black and minority ethnic offender population who require secure mental health services

### **4. Project Exclusions**

Delivering race equality in mental health for the black and minority ethnic offender population will continue to form part of the five year vision for the national action plan and the project will need to look beyond the six month lifespan to ensure further development in this area.

## 5. Stakeholders

The following key stakeholders have been identified:

- Both the black and minority ethnic offender community and local
- North West Secure Commissioning Services
- CSIP North West
- Clinical Lead for Mental Health Regional Offender Health Team
- Partners of Prisoners
- National Body of Black Prisoner Support Groups
- African Caribbean Mental Health Services
- Trafford South Asian Mental Health Project (Pakistani Resource Centre)

## 6. Deliverables

These include:

- Establish working group
- Launch of the project via consultation events
- Mapping of current provision through community engagement
- Identifying gaps in service provision and developing appropriate and responsive services
- Development of the offender care pathway
- Development of a competent workforce through training and support
- Regional and national launch of the completed work of the project to disseminate and share good practice
- Completion of Race Impact and Health and Wellbeing Assessments

## 7. Methodology

The working group will meet monthly for two hours for the six month duration of the project.

For the six month period North West Secure Commissioning Services, CSIP North West, Partners of Prisoners and the National Body of Black Prisoner Support Groups will work in partnership with each other as required to ensure the smooth operation of this project.

## 8. Project Tasks and Timetable

<b>Task</b>	<b>Start Date</b>	<b>End Date</b>	<b>People Staff</b>
Establish working group and agree project plan	June 07	Feb 08	Project partners
Community Engagement / Race Impact and Health	Aug 07	End of Nov 07	African Caribbean Mental Health Services, Trafford

and Wellbeing Assessments			South Asian Mental Health Project, POPS
Collection and analysis of data	Sept 07	Dec 07	African Caribbean Mental Health Services, Trafford South Asian Mental Health Project, POPS
Agree implementation of offender care pathway	February 08	Feb 08	Working group
Develop training / support Competencies for the Workforce	April 2008	On-going	CSIP
Interim Progress Report	Beginning Nov 07	Beginning Nov 07	African Caribbean Mental Health Services, Trafford South Asian Mental Health Project, POPS
Production of final report	Draft Jan 08	Final Report beginning Feb 08	Working group
Regional / National Launch event	Planning Dec 07	End of Feb 07	NBBPSG

## 9. Risks

Brief Description	Probability	Impact	Mitigation
Non participation	Low	Low	Working group will maintain regular communications and identify community champions

## 10. Budget

Resource	Cost
POPS / African Caribbean Mental Health Services / Trafford South Asian Mental Health Project (Pakistani Resource Centre)	£60,000
Workforce Consultant	£25,000
Events / Meetings	£7,000
Report Production	£500
	<b>Total £ 92,500</b>

## **11. Project Controls**

Governance and accountability arrangements aim to:

- Delegate responsibilities whilst maintaining focus and control of the project via the working group
- Facilitate understanding of the project, tasks and deliverables
- Provide direction and guidance on progressing project through the working group