The 'Olole Isbedel'
(Campaigning for Change)

Post Conference Report
25th February 2015
#BMEmentalhealth2015

www.mindinharrow.org.uk

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mind for better mental health
Harrow

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1. Background

On the 25th of February 2015, Mind in Harrow hosted the 'Olole Isbedel' pan London Conference at Resource for London. The aim of the conference was to transfer learnings across London about Mind in Harrow's 'Olole Isbedel' campaign; an innovative campaign highlighting the Somali community's experience of multiple disadvantage, including extreme poverty and severe mental ill health, which is inextricably linked to over representation in the criminal justice system. Over the last year, the 'Olole Isbedel' campaign has developed a unique and culturally specific evidence base to explain the root causes of the Somali communities' over representation in acute mental health services and the criminal justice system. The conference launched this local evidence base and explored the recommendations made in Lord Bradley's report and the Department of Health's Mental Health Crisis Care Concordat with particular reference to BAMER communities. This report summarises the conference activities, learnings and the experiences of delegates.

2. Delegates and Plan of the Day

80 to 100 individuals attended the conference from across London. This included approximately 25 individuals from the Somali community and 60 – 70 professionals; the majority of whom are working in the mental health and criminal justice fields (see Appendix 1). The timetable of the conference is shown below:

Time	Who	Topic
10-10:15am	Dr Frank Keating (Chair, Director of Research at Royal Holloway, University of London) Josie Hinton (Mind in Harrow)	Introduction/why are we here? Outline of day Venue/General information
10:15am -10:25am	Mark Gillham (CEO, Mind in Harrow)	Background to 'Olole Isbedel' Campaign
10:25am – 10:45am	Dr Abdullahi Fido (Consultant Psychiatrist)	Mental health needs of the Somali community and the cultural context
10:45am – 10:55am	Dr Angela Burnett	Mind's commissioning guidance for vulnerable migrants

10:55am – 11:25am	**BREAK**	**BREAK**

11:25am – 12pm	Mark Gillham Abdi Gure (Hayaan Project Coordinator, Mind in Harrow)	Olole Isbedel: findings and recommendations from year 1
12pm – 12:45pm	Talking Tables	Discussion/Feedback

12:45pm – 1:45pm	**LUNCH**	**LUNCH**

1:45pm – 2:15pm	Sophie Corlett (Head of External Relations, National Mind) Jim Symington (Consultant)	Overview of the concordat with reference to BAMER communities Local implementation
2:15pm – 2:45pm	Dr Graham Durcan (Associate Director for Criminal Justice, Sainsbury Centre for Mental Health)	Bradley Commission and recommendations

2:45pm – 3:15pm	**BREAK**	**BREAK**

3:15pm – 4pm	Speakers plus Tara Benedetti (Caseworker, PLIAS) Michael Doyle (Head of Urgent Care Review Programme (NHS Northwest London)	Panel Discussion
4pm – 4:20pm	Josie Hinton	Evaluation and Pledges
4:20pm – 4:30pm	Dr Frank Keating	Summary and Close

3. Summary of Presentations

The biographies of each of the speakers can be seen in Appendix 2 and each of the speaker's presentations can be found on Mind in Harrow's website (www.mindinharrow.org.uk). The conference was chaired by Dr Frank Keating. Frank started proceedings by outlining the context of our discussions around mental health crisis care and the court diversion process (see Appendix 3) for both the Somali community and other Black and Minority Ethnic and Refugee (BAMER) communities.

Dr Frank Keating introduced the issue identified in The Bradley Report of over-representation of certain BAMER groups in the criminal justice system and in the mental health system; with admission rates of black people being three or more times higher than those of all other groups[1]. He also introduced the recent publication of 'The Bradley Report: five years on'[2] which highlights what progress has been made since The Bradley Report and the challenges that remain in achieving effective diversion.

Mark Gillham introduced the background to the 'Olole Isbedel' campaign[3], linking the need for the campaign to the wider policy context including the introduction of the Mental Health Crisis Care Concordat[4] in February 2014 and Mind's 'Guidance for Commissioning Mental Health Services for Vulnerable Adult Migrants' (Fassil and Burnett) which will be published later this year. Mark then explained the activities and achievements of the 'Olole Isbedel' Campaign in 2014.

Dr Abdullahi Fido outlined the migration patterns and the mental health profile of the Somali community in the United Kingdom. He explained the structure of services in the United Kingdom and some of the barriers the community face in accessing services. Finally he talked about how mental ill health is conceptualised in the Somali cultural context.

Dr Angela Burnett spoke in more detail about Mind's 'Guidance for Commissioning Mental Health Services for Vulnerable Adult Migrants' (Fassil and Burnett, 2015). Angela highlighted how the guidance defines the term 'vulnerability' and posed the question: 'are these individuals hard to reach or easy to ignore?' She also outlined some of the recommendations made in the guidance about commissioning services for vulnerable adult migrants.

Mark Gillham and Abdi Gure introduced the interim campaign enquiry that was launched at the conference. The enquiry outlines 5 case study examples of the 1-1 advocacy work carried out by Abdi, the 'Olole Isbedel' Coordinator, in year 1 of the campaign. The case study examples were mapped across the criminal justice pathway and highlight the experiences of the Somali community at the interface. Abdi presented two of the case study examples and Mark outlined the key challenges and opportunities facing the mental health court diversion process that had been identified in year 1 of the campaign.

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[1] The Bradley Report: http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf

[2] The Bradley Report five years on http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_five_years_on.pdf

[3] Mind in Harrow 'Olole Isbedel' Campaign: http://www.mindinharrow.org.uk/somali-hayaan-project-moving-to-a-better-place.asp#.VRUuqPysXp0

[4] The Mental Health Crisis Care Concordat: http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

Sophie Corlett and Jim Symington introduced the Crisis Care Concordat particularly in relation to BAMER communities and its local implementation. Sophie showed data highlighting the experiences of BAMER communities in mental health services. Sophie then explained what the Concordat recommends in terms of the commissioning process and the provision of services for BAMER communities. Jim introduced the local implementation plan and some of the achievements to date. He also explained how delegates could get involved locally.

Dr Graham Durcan outlined the findings of the recent publication 'The Bradley Report: five years on'. Graham highlighted areas where the report had found that progress had been made as well as outlining the report's recommendations for the future. He particularly highlighted areas for improving the experiences of BAMER communities in the mental health court diversion process.

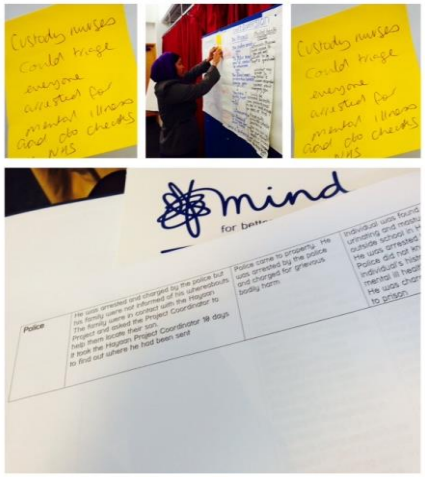
4. Talking Tables: Pan London Experiences, Challenges, Solutions and Opportunities

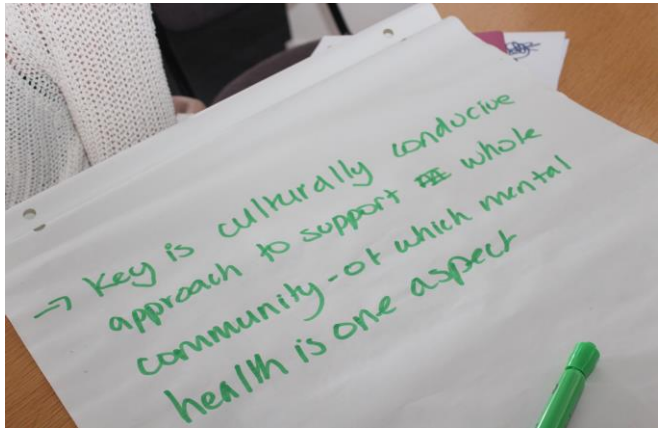
During the talking tables session delegates were asked to share their experiences (personal or professional) of the interface of mental health services and the criminal justice system and then discuss solutions/opportunities to address the challenges they had experienced or identified through the 'Olole Isbedel' campaign. Delegates recorded their discussions on flip chart paper. The raw data from the flip chart paper can be seen in Appendix 4. The key challenges, solutions and opportunities identified by delegates have been thematically grouped below:

Challenges	
1. Coordination of Services	• Poor coordination and communication between services. Delay in the production of a psychiatric report • Mental health and substance abuse are separated – need to be delivered in tandem
2. Community Issues (Somali)	• Implementation of Khat ban with no thought given to prevention or support for individuals once they give up Khat. • Lack of Somali mental health professionals to bridge the cultural gap • Stigma means that individuals with mental health problems don't always receive help/support from their own community members. For Somali community mental ill health can be seen as a punishment from God. • Denial, fear and pride often mean a lack of acceptance of any problem. • Gender and shame: women hide mental health issues. Take on a lot of responsibility within the family. Need support. • Khat ban: lack of mitigation and prevention services
3. Lack of Training	• Lack of training in mental health and cultural awareness for the police and GPs
4. Accountability/Risk/Cost	• Cost of interpreters can prohibit services using them • Individuals fall in between the gaps • Balancing the management of risk against rehabilitation
5. Language/Communication	• Consistency with interpreters makes it difficult to build relationships with community members
6. Embedding Change/Structural	• Too much pressure on Care Coordinators with ever-increasing case loads

Solutions and Opportunities	
1. Police Training	• Police receive training on basic mental health awareness and the culturally specific community support available. • Mechanisms put in place to facilitate police contact with individual's family, culturally specific advocacy services and mental health professionals.
2. Development of Community Services	• Development of community hubs/resource centres: community services have a vital role as visible 'access points' into the system and can assist with 'trust building' so that people access statutory support as and when they need it. They can also help individuals understand the culture in the UK. Use music and the arts as a tool for engagement • Development of recovery champions so that when people come out of 'the system' they have support in 're-integrating' back into the community
3. Development of Public Services (Mental Health and Criminal Justice)	• Wide spread mental health awareness training for GPs • Develop workforce diversity: existing services should better reflect the communities they serve e.g. people from the Somali community working within these services • CPNs: the establishment of custody nurses who are specifically trained in working with different cultural groups • Develop ways of interpreting mental health 'jargon' into other languages • Integrate spiritual models of distress into treatment and provide training for practitioners. • Establishing one point of contact for individuals at the interface in order to improve consistency • Prioritising the commissioning of BAMER services, identifying good models of practice • Adaptation of IAPT service to meet the needs and understandings of different BAMER groups • Research in relation to Khat ban and lack of services - mitigation and prevention services
4. Information Sharing and Communications	• Development of information sharing protocols across criminal justice and mental health. • Development of a shared assessment and case management system • Regular case management meetings across service-lines

5. Pictures of the day





6. Summary of Conference Feedback

At the beginning and end of the conference, 75 delegates completed an evaluation form designed for both professionals and Somali community members. The evaluation forms completed at the beginning of the conference highlight the need for this kind of conference; where information is provided about the wider policy context of mental health crisis care in relation to BAMER communities and delegates gain a better understanding of the Somali community's experience of the court diversion process.

Below are some key statistics from the feedback:

- 79% of professionals reported pre the conference that they knew little (36%) or nothing at all (43%) about Somalis' experience of the mental health court diversion process
- 65% of professionals reported pre the conference that they knew little (21%) or nothing at all (44%) about the mental health crisis care concordat and the Bradley Report in relation to BAMER communities
- 63% of professionals reported pre the conference that they knew little (42%) or nothing at all (21%) about Somali perspectives on mental health and wellbeing.

- 58% of Somali community members reported pre the conference that they knew little (34%) or nothing at all (24%) about the mental health crisis care concordat and the Bradley Report in relation to BAMER communities
- 48% of Somali community members reported pre the conference that they knew little (34%) or nothing at all (14%) about the mental health court diversion process. Only 14% reported that they knew a lot about this process.

The evaluation forms completed at the end of the conference highlight how the conference had successfully informed delegates about the experiences and perspectives of the Somali community in relation to mental health and the court diversion process. Delegates also felt more informed about the wider policy context.

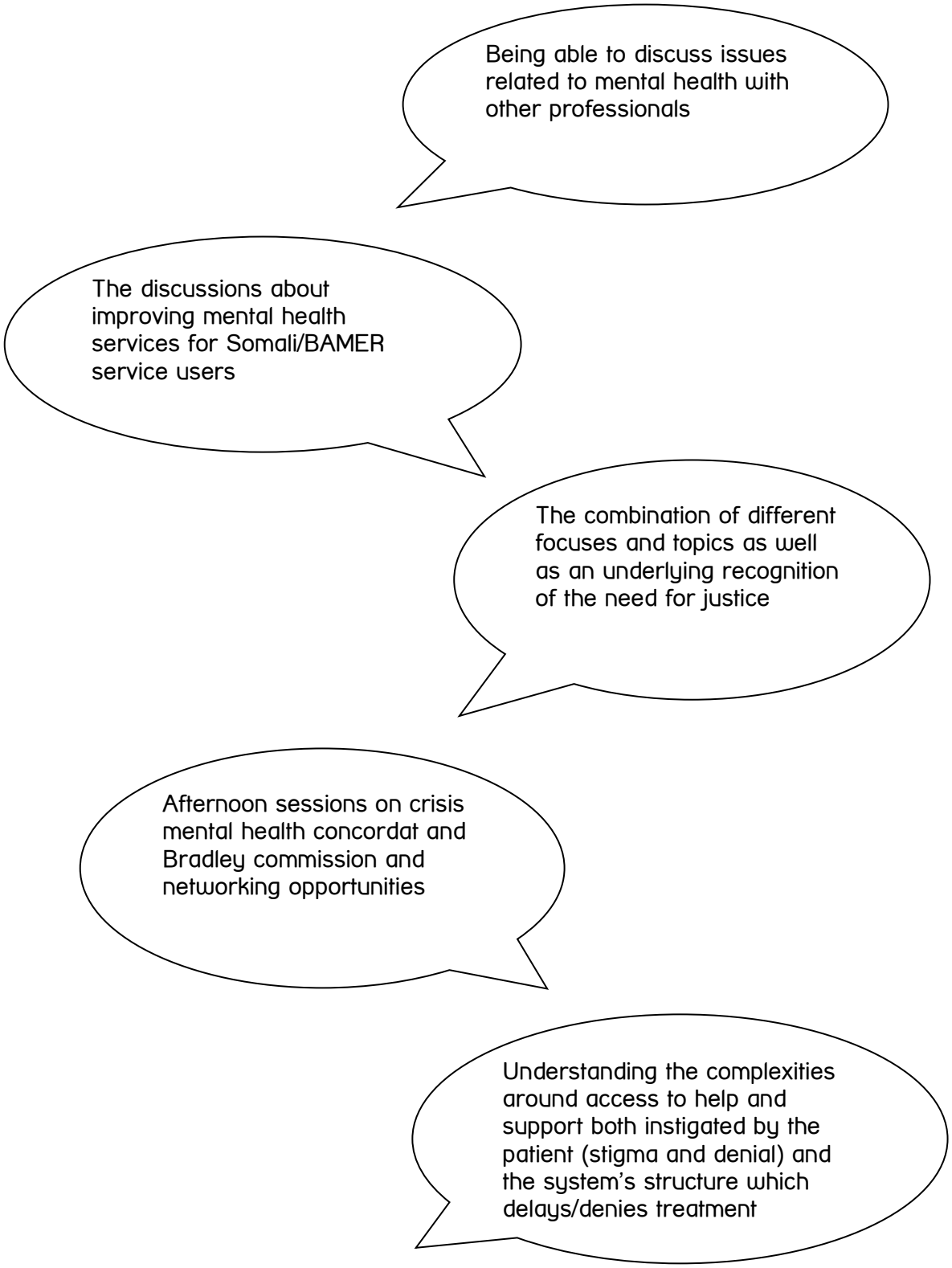
Below are some key statistics from the feedback:

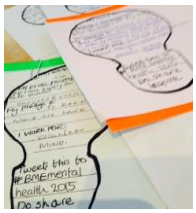
- ✓ 100% of professionals agreed or strongly agreed post the conference that they had learnt about Somali perspectives on mental health and wellbeing
- ✓ 100% of professionals agreed or strongly agreed that they had learnt more about the barriers facing Somalis in accessing mental health support
- ✓ 98% of professionals agreed or strongly agreed post the conference that they know more about the mental health crisis care concordat and the Bradley report in relation to BAMER communities

- ✓ 95% of Somali community members reported that at the conference they had learnt a lot (57%) or quite a lot (38%) about the mental health crisis care concordat and the Bradley Report in relation to BAMER communities
- ✓ 90% of Somali community members reported that at the conference they had learnt a lot (52%) or quite a lot (38%) about the mental health court diversion process

7. Comments from Delegates

Delegates were asked what they enjoyed about the conference – here are some of the comments:





8. Lightbulb Pledges

Delegates were asked at the end of the conference to write down a pledge; a learning or action they would try and take forward as a result of the conference. Here are some of the pledges that were made:

Further research on making therapy more useful for Somali service users

I will increase the percentage of Somali people accessing mental health services

Recruiting more mental health champions from the Somali community to tackle stigma and raise awareness

I will continue tirelessly to engage those hard to reach and find innovative ways to foster psychological therapies and healing

Think more carefully about cross-cultural views of mental health in psychological therapy

To work with Barnet Mind to improve services for transition from children to adult services for mental health

9. Recommendations

Recommendations	Actions to take forward in 2015 from local enquiry in 2014
Police training	• The Olole Isbedel Campaign Coordinator is introducing an information sheet for Somalis detained by the police. This sheet is being piloted by South Harrow police station. The sheet is written in Somali and informs individuals of their right to an assessment and diversion if they have a mental health problem. 'Mental health problems' are described in a way that the community will understand. The sheet will be available on the police database in English as an information tool.
Development of Community Services	• As part of Mind in Harrow's work around improving the effectiveness of commissioning for vulnerable migrants, we have started work with the 'Like Minded' team who are developing the northwest London mental health and wellbeing strategy. As part of this we plan to recommend the incorporation of the development of 'cultural hubs' which can be visible 'access points' into the mental health system for BAMER communities. • The Olole Isbedel campaign will aim to raise the profile of existing services that support the discharge of individuals from the criminal justice and mental health systems back into the community; for example encouraging people from the Somali community to apply to the Independent Visitor Scheme and to be available to visit people from their community who are detained in local police stations.
Development of Public Services (Mental Health and Criminal Justice)	• Mind in Harrow will be developing and delivering a user-led training across 8 CCGs in northwest London to contribute to the implementation of this aspect of the Mental Health Crisis Care Concordat. • Mind in Harrow are continuing there work around brokering a dialogue between vulnerable migrant communities and commissioners of mental health services. During the next phase of this work we will be working on influencing the northwest London urgent care review service specification and implementation. As part of this we will be advocating for the inclusion of street triage and the placing of culturally competent mental health professionals in police stations/at the point where individuals are detained. • The Bridging Cultures Project at Mind in Harrow works in partnership with faith communities to try and develop an understanding of how spiritual models of distress can be incorporated into treatment. This importance of this kind of work will be highlighted in our work with

	commissioners of mental health services. • In order to improve the understanding of mental health/mental ill health at different stages of the criminal justice/mental health interface, the Olole Isbedel Campaign will continue to advocate for the introduction of a 'cultural brokerage' model of practice and other models of good practice for BAMER communities. The 'cultural brokerage' approach has already been included in the northwest London urgent care review service specification. • The Olole Isbedel Campaign will be making the case to public health about the need to coordinate with other services to respond to the social, economic and health consequences of the Khat ban in July 2014.

10. Appendix 1: Delegates: List of Services Represented

Brent Mind
National Mind
Multilingual Wellbeing Service
SIDA
Certitude
Each Counselling
Bromley and Lewisham Mind
Camden Council
Blenheim CDP
Mind in Barnet
YASS
Dunning Hall
City and Hackney Mind
Barnet Association of Tamil Elders
Northeast London NHS Trust
Social Finance
Trust for London
National Service User Network
Mind in Haringey
Westminster Drug Project
Hillingdon Healthwatch
Hammersmith and Fulham Mind
IMHA
Islington Council
Islington Mind
SLAM
Barnet Centre for Independent Living
Refugee Support Services NELFT
Refugee Therapy Centre
Barnet CCG
The River Crisis House
IAPT Waltham Forest
Harrow Community Recovery Team
South Harrow Police
Voluntary Action Camden
ROTA
London Metropolitan Police
Barking and Dagenham IAPT service
Waltham Forest Brief Intervention Service
Harrow Council
Waltham Forest Mental Health Services
Migrants Resource Centre
Lambeth Crisis Services
Centra Care and Support
Hounslow Crisis Resolution Team
Muslim Hands
South London and Maudsley NHS Trust

II. Appendix 2: Speakers' Biographies

Dr Abdullahi Fido, MD; MRCPsych; Phd has worked in the field of clinical and academic psychiatry for over 40 years in 5 countries across 3 continents. He has published numerous articles on subjects related to mental health issues. He is a Consultant Psychiatrist and Clinical Tutor at the Global Medical Education Centre in the UK and a visiting Consultant Psychiatrist at the Kuwait Centre for Autism. He was formerly professor and chairman of the department for Psychiatry and College of Medicine at Kuwait University.

Dr Angela Burnett is lead doctor at Freedom from Torture, working with survivors of torture, and a GP at the Greenhouse Practice, Hackney, caring for homeless and vulnerable people, many of whom are migrants. She writes on the health of refugees and survivors of torture, including a BMJ series and resource pack for frontline workers, and has recently written guidelines for commissioning mental health services for vulnerable migrants. She has mentored refugee doctors and assisted in developing UK-wide health services for refugees and torture survivors.

Sophie Corlett is Director of External Relations at Mind. She has been at Mind since 2002 and is responsible for Mind's policy and campaigning, media, communications, legal and information services. Sophie is also responsible for the delivery of the Crisis Care Concordat project at Mind, a project funded by the Department of Health to support local areas across England to improve their response to people in mental health crisis. Amongst other things, Sophie is on the Management Board of the National Collaborating Centre for Mental Health which develops guidance on care and treatment for people with mental health problems for NICE and is on the trustee board for both the Centre for Mental Health and for National Voices. She is a regular spokesperson for Mind in the media.

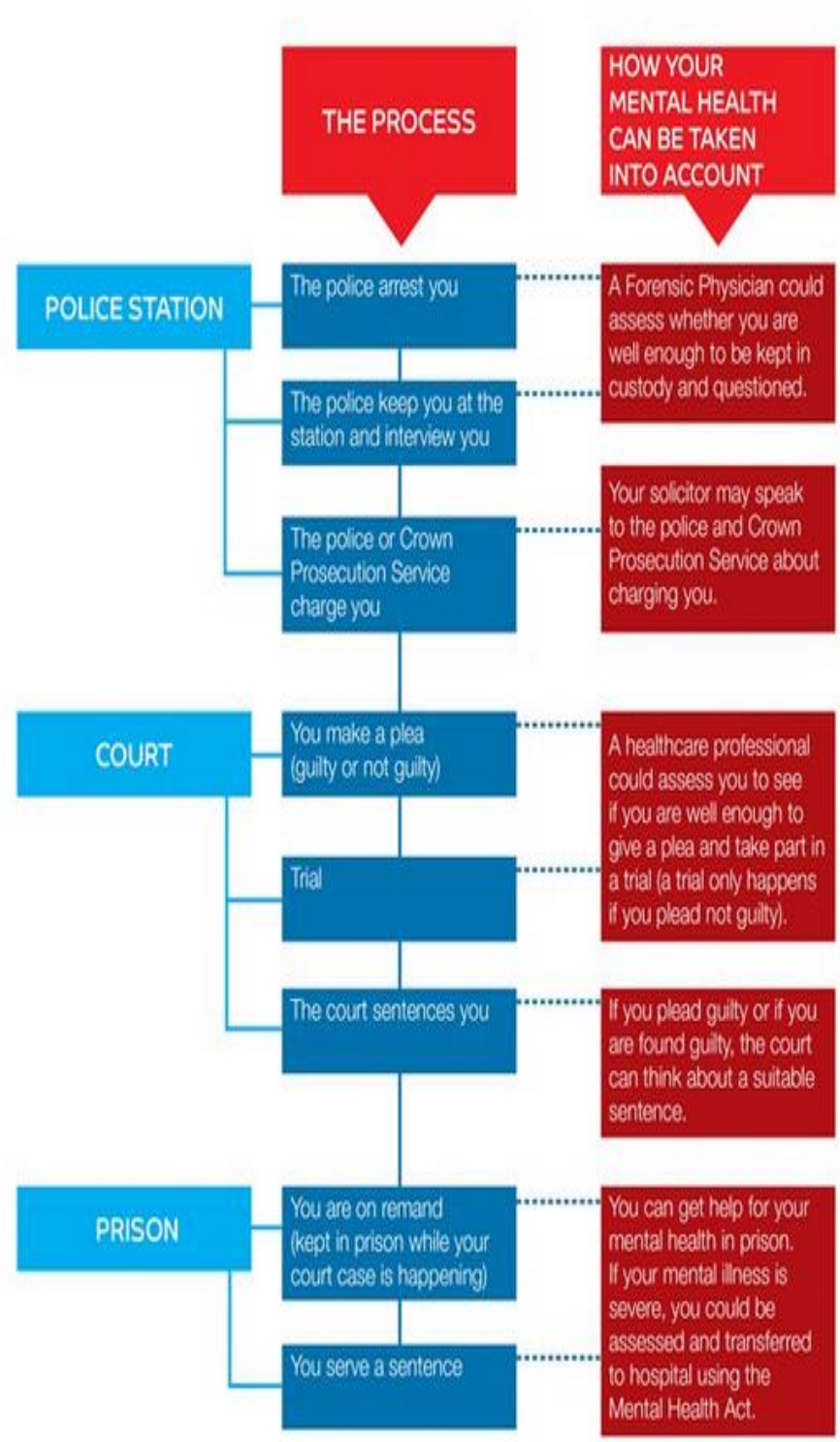
Jim Symington, Director Symington-Tinto Health and Social Care Consultancy has worked on behalf of HMG with 22 national organisations to develop the 2014 national Concordat 'Improving outcomes for people experiencing mental health crisis' – currently, together with Mind, he is supporting localities to complete local Declarations and action plans. Jim's previous work in mental health policy development and implementation includes the 'Implementing Recovery Organisational Change (ImROC) Project (Centre for Mental Health and NHS Confederation), the 'History of Psychiatry' (Wellcome Trust) Mental Health Act Implementation Advisory Group (HMG), the Re-focused Care Programme Approach Review (DH) and the drafting team for the 'No Health without Mental Health Strategy' for England (HMG 2011). He worked as a programme director for the National Mental Health Development Unit/National Institute for Mental Health in England and for the London Development Centre for Mental Health leading national and regional programmes including mental health care pathways. Before joining the NHS as a manager, Jim was an Approved Social Worker and manager in social care.

Dr Graham Durcan has worked in the mental health field for over 32 years and is a psychiatric nurse by background. He has worked in a variety of settings, including CAMHS, community, acute inpatient, high secure NHS, a prison and has been full-time with the Centre for Mental Health since 1996. Graham's work with the Centre has involved research, evaluation and service development work in a variety of areas and these include CMHTs, assertive outreach, crisis resolution, early intervention in psychosis, criminal justice, veterans mental health, secure mental health care, acute inpatient care and whole systems work. For the last ten years he has lead the Centre for Mental Health work in criminal justice and has worked on projects covering: prisons, secure care services, policing, liaison & diversion, resettlement, probation and gangs. Graham has contributed to work programmes run by the World Health Organisation's Prisons Programme and the International Committee of the Red Cross.

Tara Bennedetti's current role at PLIAS Resettlement as the Community Engagement Co-ordinator supports individuals from the community who have been through the criminal justice system. Tara has experience of actively promoting measures which reduces inequalities between sections of the local community. At PLIAS Resettlement, Tara provides direct support to ex-offenders and is currently supporting Somali ex-offenders from the local community who have been through the criminal justice system to ensure better outcomes are achieved. Prior to joining PLIAS Resettlement, Tara worked as a Nursery Practitioner working with children and their parents to support their development. Tara was involved in developing and providing positive behavioural strategies in line with the Welfare requirements of EYFS

Michael Doyle currently leads the Mental Health Urgent Care redesign programme across the 8 CCGs in North West London (national pathfinder for urgent care). The programme incorporates several strands including clinical pathway design, demand and patient flow mapping (health, criminal justice, local authority, voluntary sector and public health), access standards development, assurance reporting, workforce planning, and business case development. Previously Michael was the Interim Programme Director for West London Mental Health Trust, managing a large scale, integrated and systemic Transformation Programme in local mental health services, with 3 CCGs, local authorities, third sector providers and patient/service user and carer participation

12. Appendix 3: How does the system work? A flowchart (Rethink Factsheet)[5]



5 Rethink (2013) Mental health and the criminal justice system (police court, prison), Factsheet.

13. Appendix 4: Experiences, Challenges, Solutions/Opportunities

The raw data of the flipchart paper from the talking tables discussion:

Experiences

70s and 80s mental health conditions not taken into account on arrest

Process takes too long

Court outdated system

Gender and shame: women hide mental distress more; community - reputation of the family; stigma about taking medication/non-compliance; interpreters not conveying how people really feel. Lots of responsibility placed on mothers/women for family and person experiencing mental distress

Arrested for such minor offences (flashing - 4 months on remand, court, waste of time!)

Heavy handed policing and prejudice

Lack of mental health professional involvement

Advocacy only called at last minute - none unless you complain (Voiceability what does it involve?)

People with mental ill health from Somalia won't admit they have a mental health problem due to stigma and concern they will not get support. People wander the streets - e.g. Sheffield

Good relationship and communication between liaison and diversion in police stations, court and crown court in NE London

Issue with young person under 25 being held in an adult mental health ward where they are subjected to bullying - compounds re offending cycle (in Hillingdon)

Abuse: lady known to CMHT, reported to police 10m ago, ongoing distress for mental health issues, communicating her experience brings back her experiences, no formal psychological support (waiting list).

Substance misuse/mental health: stigma attached to mental health, no access to services, no therapies - different engagement, services to reflect the needs, need to access alternatives, anonymity

Too much pressure/workload on care coordinators which means when service user was imprisoned they were off the radar

Challenges

Capacity issues

Delay in Psychiatric report

Legal system: legal aid delay - solicitor not known client - solicitor requests psychiatric report - consent to share issue

Communication - confidentiality issues

Lack of research in relation to Khat ban and lack of services - mitigation and prevention services

No mental health workers in police stations but Hendon court - 3 mental health workers placed in court

Mental health/substance abuse separate - need to be delivered in tandem

Proactive screening in courts by forensic mental health staff - is this the right place for assessment? Very short window with multiple cases

Police station: VCS services placed/respond for assessment - could police have training for this? System separates out multiple needs, not the person in the custody

Interface CMHT/CJS very complex for everyone - even more so for BME/migrant community; language, mistrust etc.

Referrals - a big barrier to entry

Lack of Somali mental health professionals

Lack of training around culturally specific issues

Passing the buck by CMHT/recovery/crisis team/GPs

Safety of community

Lack of communication among authorities

Stigma built in some so that they don't want their own community to help them

The cost of interpreters is prohibitive and off putting and its also difficult to book the same interpreter twice which is a barrier to relationship building

Balancing risk against their rehabilitation

Denying mental health - immediately think ill health

The system itself prevents treatment - needs to be improved

More training needed

Stigma

Pride

Fear/not accepting mental ill health - loss of benefits, children etc.

Racism is the real problem from commissioning to service delivery

Continuity of CPA in prison

How police can think differently

Other

How can we improve mental health services in custodial estates as not all can be diverted?

Solutions/Opportunities

Police need more training

Build trust within family and community re mental health so that people can open up

Train GPs to understand BME cultures and their experiences

Better visibility in the community to act as another access point

Develop the existing services to better reflect the communities they serve

Increasing number of access points

Information sharing: improve protocols to enable sharing of information and understanding of the various commissioning pathways

Need for continuity and better management of service users' transition from one area to another

Partners in the CJS and mental health services understanding each others roles and respecting each others remit

Use of court diversion video link

Custody nurses - are they nationwide? Could be trained on specific cultural competency relating to the Somali community to help identify need

Role of solicitors

Better liaison between services with representation from community groups

Routine checks on arrest

Training NHS staff/police

More people from the Somali community working in these services

More established communities could share experiences

Someone to bridge common beliefs about mental distress held in communities and relevant treatment/support

Campaign against labelling people with a mental health diagnosis

Education

Police to contact family, mental health professionals, advocacy - full assessment

Need official statistics

Support via building trust

Preventative and crisis work go hand in hand

Key is culturally conducive approach to support whole community - of which mental health is one aspect

CPNs coming up to speed with diverse society

Education on both sides

Different strategies

Partnerships - joined up thinking/information sharing

Take reasonable aspects of cultural practices

Regular meetings across health, CJS - MARAC awareness

Don't be judgemental

Induction and training

Clear communication between teams and wider services

Have transcultual nurses - more specialisation

Stop money and beds as the first hurdle

Integrated services which alert police to individuals known to mental health services

Social justice within BME communities and prevention programmes

Extensive training provided to health professionals to promote appropriate services being provided in the community e.g. culturally appropriate

Ensure translators with a mental health background are used when dealing with service users

Translate mental health language

People in system need advocates to guide them

How can CMHT track people in CJS? In Harrow, a shared assessment system; data sharing necessary; case management systems

Training for police in basic mental health - they know who to call

Partnership working - drugs, mental health not separate

Police linked into services, better training

Joint assessment (reduce assessment fatigue and paperwork)

Data sharing - track people with mental ill health through the CJS

Mental health training for police/probation

More information about options available to Somali community

Mental health training for GPs

Spiritual training (combination with medical model) - psychiatrists, CPN and CMHT

Police to have more understanding of mental health problems

Street triage

Abbreviation of ABCDE (appearance, behaviour, communication, D and environment)

Prevention of time delay (between police and NHS) by giving access to police medical officer

Communication

Keeping all the agencies under one umbrella

Recovery champions within the community

Group of people working together from different communities to understand the culture

Making them understand the culture in the UK and include other cultures as and when necessary during discussions/treatment.

HPCCG and Academy of Civic Justice

Training for the police around mental health and learning disabilities from mental health practitioners based in police station

Training for other staff e.g. store managers who lack understanding

Promoting mental health and awareness

More information on mental health for individuals experiencing or going through CJS - more engagement

Mutual respect

Consistent contact person

Narrative approach - using language of the person

Police access to mental health provision via telephone line

More comprehensive mental health assessments at point of contact with CJS

Systemic screening for mental health patients at point of entry into CJS

Commissioning of BME services should be prioritised and good practice models should be developed.

Appropriate adult role/advocacy

Forensic assessment

Request for legal information

Mental health street triage service