CONSULTATION RESPONSE

Race on the Agenda

The London Health Inequalities Strategy

January 2010

1. Introduction

1.1 About ROTA

Race on the Agenda (ROTA) is one of Britain's leading social policy think-tanks focusing on issues that affect Black, Asian and minority ethnic (BAME) communities. Originally set up in 1984, ROTA aims to increase the capacity of BAME organisations and strengthen the voice of BAME communities through increased civic engagement and participation in society.

ROTA's Articles of Association state that the charity is set up "to work towards the elimination of racial discrimination and to promote equality of opportunity, human rights and good relations between persons of different groups".

For historical and demographic reasons, our work prioritises London, but our activities and a number of our projects have national and international significance. To this end we work in close partnership with our membership and others interested in race equality, human rights and the promotion of good relations.

Our presence in London is enhanced by our regional network, **MiNet,** a BAME network of networks, which joined ROTA in 2002 to strengthen the voice for London's BAME voluntary and community sector (VCS) in the development of regional policy.

1.2 ROTA definition of BAME and approach to race equality

ROTA works on social policy issues that have an impact on race equality and BAME communities. We use the term BAME to refer to all groups who are discriminated against on the grounds of their race, culture, nationality or religion. The ROTA definition which includes but is not exclusive to people of African, Asian, Caribbean, East European, Irish, Jewish, Roma and South East Asian decent. ROTA adopts a holistic approach to race equality and works in partnership with other VCS organisations that complement its expertise and have a similar vision

1.3 Methodology for this response

ROTA's policy work is evidence based in the sense that everything we do is informed by the views and real life experiences of BAME communities and the organisations that are set up to serve them. We collect evidence through:

- Action research (qualitative and quantitative surveys)
- MiNet
- Events, consultations and conferences
- Working in partnership with others.

This response is based, in particular, on evidence generated through:

- ROTA's work on the previous Mayor's Health Inequality Strategy
- ROTA's work on the 'Equal Life Chances for All'[1]
- ROTA's 2009 consultation with London's BAME VCS, which focused on five policy areas, one of which was health
- An event held by ROTA and BEAM-EM in 2009 about mental health and BAME communities
- ROTA's Female Voices in Violence project
- ROTA 2007 report on homelessness.[2]
- ROTA submission to the Joint Committee on Human Rights on the human rights of older persons in healthcare in February 2007.

2. Executive summary

2.1 Overall comment

ROTA welcomes the Mayor's draft Health Inequalities Strategy. We see its development as a much needed opportunity to address the persistent health inequalities faced by London's BAME communities. We are particularly pleased with how it links to other areas of the Mayor's policy that relate to the wider socio-economic determinants of health, including the London Plan and the Transport Strategy. We are also pleased with the recognition of the role of the voluntary and community sector (VCS) in addressing health inequalities.

As is well documented, BAME communities face persistent and particular health inequalities. Yet, the strategy makes very little reference to this. As such, it is unclear how the Strategy's objectives will translate into practice that benefits BAME communities; it risks improving health and well-being generally at the expense of addressing health inequalities. It should acknowledge and include information about the particular social-economic health determinants, risk factors, illnesses and barriers to accessing health and social care services experienced by BAME communities and targeted and specific measures in response.

[1] Greater London Authority (2009) *Equal Life Chances for all*. Mayor of London
[2] ROTA (2007) *The visible and hidden dimensions of London's homelessness: A Black, Asian and minority ethnic account*

The Strategy should incorporate the concept and language of substantive equality, rather than formal equality. Formal equality, which treats everyone equally, even in unequal situations, risks exacerbating inequality. Substantive equality, on the other hand, recognises that entitlements, opportunities and access are not equally distributed through out societies. Substantive equality acknowledges that where policy is tailored to the majority group, other people with different needs and circumstances may not be considered. It recognises that different groups may need to be treated differently and encourages positive action to correct situational imbalances and ensure equality of outcomes.

Additionally, the Strategy does not plan adequately enough for the health issues and inequalities that will emerge as a result of the rapidly changing ethnic demographic, where it is predicted that over the next 20 years the BAME population will increase from 33% (2006) to 39% in 2026.[3]

The Integrated Impact Assessment (IIA) of this Strategy does not include a detailed and specific Equality Impact Assessment (EIA). ROTA believes the EIA does not comply with the Race Relations Amendment Act 2000. This short-coming is recognised in the IIA itself. In order to ensure compliance with the Race Relationships Amendment Act 2000, the GLA must conduct a full and thorough EIA. Additionally, we support the recommendation in the IIA that a detailed EIA, identifying the needs and particular requirements of all equality groups, is undertaken of the Delivery Plan that will accompany the final Strategy.

Rather than respond to the consultation questions in turn, this response makes a number of comments in relation to each section of the Strategy and a series of recommendations. We have included a level of detail which we are aware may be too much for this Strategy, but which we hope will inform its Delivery Plan. We would welcome the opportunity to continue to support GLA staff on this work given that health was identified by respondents to our 2009 consultation with the BAME third sector as one of their top five policy priorities.

2.2 Recommendations

Overall recommendations

1. The Strategy should be developed based on the concept of substantive rather than formal equality by including targeted and specific action to address the health inequalities faced by BAME communities. Given the scale of such health inequalities, the Mayor should consider developing a Race Health Inequality Action Plan that is both separate from and integrated into the generic Delivery Action Plan that will accompany this Strategy.
2. The Mayor should reinstate the GLA equality and diversity team to ensure substantive equality is mainstreamed throughout its policies and compliance with equalities legislation.
3. The leader of the London Assembly should be assigned an equalities remit.
4. A thorough Equality Impact Assessment of the Health Inequalities Strategy must be undertaken in order to ensure compliance with the Race Relations Amendment Act (2000).

[3] Greater London authority (2009) *The State of Equality in London Report*

Objective 1: Empowering individuals and communities

5. The Strategy should explicitly acknowledge the barriers faced by BAME communities in engaging in decision-making and include specific actions to address the, for example, by using Mayor's relationship with PCTs and Local Authorities to influence the latter's practices on engaging and supporting marginalised groups.
6. ROTA's recommendations[4] about the Community Voices for Health Network should be taken on board to ensure BAME communities are meaningfully involved. Linked to this network, a BAME stakeholder group should be established to advise on the development of this Strategy's Delivery Plan and monitor its progress.
7. The Mayor, through this Strategy and other means, should explicitly recognise the unique and vital role BAME organisations play in addressing inequality and strengthening cohesion. The Strategy and Delivery Plan should include points to ensure greater support and sustainable funding for the BAME sector by, for example, raising awareness about the BAME VCS among local statutory partners and encouraging them to develop inclusive commissioning and procurement practices.
8. The Strategy should explicitly refer to and include measures to address the unequal educational outcomes for BAME communities and make stronger links to the Mayor's 'Time for Action' Strategy[5] and the work taking place under it.
9. The Strategy and its Delivery Plan should include measures aimed at recognising the potential of supplementary schools in addressing health inequalities.

Objective 2: Equitable access to high quality health and social care services

10. The Strategy should include measures that ensure the barriers BAME communities face in accessing health services.
11. The Strategy should follow up on the GLA's previous work, Health and Race Equality Appraisal of Local Area Agreements, which aimed to raise awareness of London Boroughs Race Equality Schemes.
12. The GLA should support the Equality and Human Rights Commission in monitoring the compliance of health and related services with the Race Relations and Human Rights Acts and potentially a Single Equality Act which will extend the positive duties to all equality groups, including to externally procured services.
13. The Mayor should advocate for the continuation and roll-out of the Pacesetters programme.
14. The Mayor should include measures in the Strategy aimed at increasing awareness among healthcare providers in London of their obligations under the Human Rights Act and among those who experience health inequalities of their human rights.
15. The Strategy should explicitly reference the particular mental health issues of BAME communities and include measures to address them. In doing this, drafters of the Strategy should refer to ROTA's recent response to the government's draft strategy on mental health[6]; the work by the Breaking the Circles of Fear Team at the Sainsbury Centre for Mental Health[7], which considered the business case for race equality in the mental health system; the work of the Afiya Trust, which

[4] ROTA (2009) *Response to the Terms of Reference for the Community Voices for Health Network*. This response recommended that places should be reserved specifically for BAME organisations to ensure representation; and that those representing particularly marginalised communities, which are typically under-resourced themselves, are resourced to engage.
[5] GLA (2008) *Time for Action: Equipping Young People for the Future and Preventing Violence.*
[6] *New Horizons: Towards a shared vision for mental health*
[7] Sainsbury Centre for Mental Health (2006) *Costs of Race Inequality*

specialises in the impact of mental health policy on BAME communities; and the Equality Impact Assessment of Improving Health, Supporting Justice[8], which ROTA was involved in developing.

16. The Strategy should allow for a programme of learning about the diverse VCS for health commissioners. Such work could build on the 2007/08 work by the Housing Associations' Charitable Trust (HACT) which worked with commissioners and refugee and migrant community organisations and produced a guide.[9] The Strategy should also draw a link with work highlighted in 'Partnership in Public Services: An action plan for VCS involvement'[10], which states that the government will "promote the use of social clauses in championing the social value that the VCS can create and enable innovative approaches to grow". The Strategy should recommend that commissioners always take into account the "social dividend" provided by BAME organisations.
17. The Strategy should support the engagement of the BAME VCS in the delivery of public services by including support around commissioning for smaller and less formal VCS organisations in the work of the London Teaching Health Network and by encouraging local statutory services providers to develop more inclusive commissioning practices.
18. GLA should encourage local and regional statutory partners to maintain grants programmes to support the key role identified within this Strategy for smaller VCS organisations, which make up the majority of the BAME VCS.

Objective 3: Reduce income inequalities and minimise the negative health consequences of relative poverty

19. The Mayor should develop his draft Economic Development Strategy into one which is more responsive to the specific issues faced by BAME communities as detailed in MiNet's consultation response[11] and its 2008 report[12] on the recession.

Objective 4: Health, work and well-being

20. The specific inequalities faced by BAME communities in terms of employment and the disproportionate impact of the recession on BAME communities should be explicitly referenced in this part of the Strategy and addressed in the Mayor's Economic Development Strategy.

Objective 5: Healthy Places

21. The Mayor should acknowledge the inextricable links between inequality and community tension, where it exists, in all his policies that refer to community cohesion, as done so by Lord Justice Moses in his judgement on the Southall Black Sisters' case against Ealing Council.
22. This Strategy should explicitly consider how to address racist crime and influence the work of other relevant agencies to ensure efforts to address it are stepped up.
23. The Strategy must acknowledge that there are social issues which impact on the health of particular groups and not others, which require specific responses, and

[8] Department of Health (2009) *Equality Impact Assessment of Improving Health, Supporting Justice.*
[9] Perry, J. & El-Hassan, A (2008) *More responsive public services? A guide to commissioning migrant and refugee community organisations*. Joseph Rowntree Foundation
[10] Office of the Third Sector (2006) *Partnership in Public Services: An action plan for third sector involvement*
[11] MiNet (2010) *Response to the Mayor of London's Draft Economic Development Strategy*
[12] MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector.* London: ROTA

include measures to ensure they are addressed through the Strategy's Delivery Plan.

24. The Mayor should consider the recommendations from ROTA's Female Voices in Violence project which will report in February 2010. In particular, the GLA should work with ROTA to develop an appropriate multi-agency strategy to supporting women and girls who experience gang-related violence, including housing, health, social care, education and children's services and criminal justice agencies, which ensures that this issue is considered at local levels. Additionally, this Strategy should work through the implementation of the Time for Action sand The Way Forward strategies to see serious youth violence as a public health issue, and that the mental, physical and sexual health needs of those associated with and/or impacted by serious youth violence are met – in order to reduce offending rates and victimisation, increase confidence in statutory support and improve the rates of inclusion and empowerment amongst BAME young people.
25. This Strategy and the Mayor more generally should address concerns about the victimisation of BAME communities by law enforcement agencies and other parts of the criminal justice system.
26. Given the severity and scale of the impact of the criminal justice system on BAME communities, it should be considered within the Strategy in relation to Objective One, Two, Four and Five. In particular, the Mayor should:
    - Seek to influence the delivery of health and social care services within prisons to ensure they are beneficial to BAME people.
    - Consider and engage with work taking place under the Department of Health's Action Plan on Offender Health[13]. This Plan draws together the recommendations from Lord Bradley's review[14] of people with mental health and learning disabilities in the criminal justice system and the response to the consultation on the draft Improving Health, Supporting Justice Strategy[15]
    - Support the recommendation from The Corston Report[16] for a "women-centred approach" to female offending.
    - Link this Strategy with existing structures such as the health pathway of the London Resettlement Board and the Regional Offender Management Service.
27. Link this Strategy with existing structures such as the health pathway of the London Resettlement Board and the Regional Offender Management Service.
28. This Strategy should take forward the recommendations from research by the Commission for Racial Equality on the health inequalities faced by BAME people in the prison system.

Cross-cutting objective: Knowledge and learning

26. The commitment made in the Strategy to address gaps in information and data on health inequalities should be prioritized within the Delivery Plan, with a focus on BAME communities. This commitment should be reinforced with more robust targets and indicators that track progress by ethnicity.

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[13] To find out more please visit www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108606

[14] Rt Hon Lord Bradley (2007) *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*

[15] Department of Health (2007) *Improving health, supporting justice: a consultation*

[16] Baroness Corston (2007) *The Corston Report*: A *report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*. Home Office

27. The knowledge and data held by BAME organisations needs to be acknowledged as distinct from that held by generic VCS organisations and supported explicitly within this section. There is a lot of work already going on that is making better use of such knowledge and data, for example by the Joseph Rowntree Foundation and the Information Centre about Asylum Seekers and Refugees[17], which should be built on.
28. Work should take place under this part of the Strategy that evidences the value of BAME organisations in addressing health inequalities. Case-studies should be collected and disseminated to incentivize statutory agencies to work more supportively with them.
29. All the indicators proposed in this section should gather data which can be broken down by ethnic group, but also by other equality groups, to ensure understanding is developed about multiple-inequality. Additionally, data should be collected in relation to the particular health issues faced by BAME communities. Success should be judged, in part, by evidenced reductions in the health inequalities faced by BAME communities. The categories included under 'major killers' and 'long-term limiting illnesses' should include illnesses that only or disproportionately affect different ethnic groups. Drug consumption should be included under 'health related behaviours'. This field should also capture 'type of drug' consumption. Experiences of discrimination, hate-crime and other forms of abuse should be included under 'socio-economic variables'. The 'Social capital and psycho-social factors' category should include indicators about levels of social exclusion, for example, 'feeling included', 'feelings of isolation' and 'levels of participation' for example, as councillors, school governors etc. The 'Access to healthcare and health system' category should include indicators which capture data about pathways through the healthcare system, as well as the factors which lead to health issues.
30. The Strategy should include measures which address and enable learning about multiple-inequalities – that is, the health circumstances of those who belong to more than one equalities group, such as for example older BAME people.

Section about partners

31. The BAME sector should be explicitly listed as a key partner in the delivery of this strategy. Regional BAME infrastructure organisations, as well as frontline BAME organisations should be supported to engage, with a regional BAME organisation, such as ROTA represented on the London Health Commission.

[17] http://www.icar.org.uk/1609/making-better-use/making-better-use-of-data-and-information.html.

3. Full response

3.1 Overall comment

ROTA welcomes the Mayor's draft Health Inequalities Strategy. We see its development as a much needed opportunity to address the persistent health inequalities faced by London's BAME communities. We are particularly pleased by how it links to other areas of the Mayor's policy that relate to the wider socio-economic determinants of health, including the London Plan and the Transport Strategy. We are also pleased with the recognition of the role of the voluntary and community sector (VCS) in addressing health inequalities. We give comments later aimed at distinguishing the unique and vital role played by BAME organisations in addressing health inequalities, from that of the mainstream VCS.

As is well documented, BAME communities continue to face unequal treatment and outcomes in a range of key social policy areas including health, housing and employment. In some areas, such as in education and criminal justice, policies actually directly increase unequal life chances for some BAME communities. While the Strategy broadly acknowledges inequality exists, it is unclear how its objectives will translate into practice that addresses it for the benefit of BAME communities. The Strategy should acknowledge and include information about the particular social-economic health determinants, risk factors, illnesses and barriers to accessing health and social care services experienced by BAME communities and include targeted and specific measures in response. In its current form, it risks improving health and well-being generally at the expense addressing health inequalities. It needs to incorporate the concept and language of substantive equality, rather than formal equality. Formal equality, which treats everyone equally, even in unequal situations, risks exacerbating inequality. Substantive equality, on the other hand, recognises that entitlements, opportunities and access are not equally distributed through out societies. Substantive equality acknowledges that where policy is tailored to the majority group, other people with different needs and circumstances may not be considered. It recognises that different groups may need to be treated differently and encourages positive action to correct situational imbalances and ensure equality of outcomes. If based on the concept of substantive equality, this Strategy might, for example:

- Address health issues that are only experienced by or disproportionately affect specific communities. For example there are higher rates of coronary disease among Pakistani and Bangladeshi groups, hypertension among African-Caribbean groups, diabetes among South Asian and African-Caribbean groups, sickle cell disorders and thalassaemia among African and African Caribbean communities, and a growing rate of prostrate cancer among BAME men.
- Address the social issues that only impact or disproportionately impact on the health of certain BAME communities. For example, ROTA's Female Voices in Violence project has identified significant unmet health needs of many young BAME women who are victims of sexual violence as a result of being gang associated.

Additionally, the more generic elements of the Strategy need to be rethought through a 'race lens'. For example, the sub-section about 'Life expectancy', a key indicator of health inequality, refers to differentiations in life expectancy by geographical area, gender, homelessness status, but not ethnicity. ROTA would like to facilitate this process. Given

that our membership of the London Health Commission has lapsed we suggest we renew that relationship.

Lack of consideration of the specific health inequalities of BAME communities within this Strategy could exacerbate the institutional racism that persists in health and related services. Although, the Lawrence Inquiry and Scarman report focused on racist behaviour by the police, their findings brought evidence of a discrimination culture throughout public services. In particular, Macpherson who carried out the Lawrence Inquiry concluded that there exists "institutional racism across public services". Institutional racism was defined as: "The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages BAME people. [Racism] persists because of the failure of the organisation to adequately recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease".[18] Ten years on from the death of Stephen Lawrence we are still faced with the challenge of institutional racism.

Additionally, the Strategy does not plan adequately enough for the health issues and inequalities that will emerge as a result of the rapidly changing ethnic demographic, where it is predicted that over the next 20 years the BAME population will increase from 33% (2006) to 39% in 2026.[19]

The Integrated Impact Assessment (IIA) of this Strategy does not include a detailed and specific Equality Impact Assessment (EIA). ROTA believes the EIA does not comply with the Race Relations Amendment Act 2000. This short-coming is recognised in the IIA itself. In order to ensure compliance with the Race Relationships Amendment Act 2000, the GLA must conduct a full and thorough EIA. Additionally, we support the recommendation in the IIA that a detailed EIA, identifying the needs and particular requirements of all equality groups, is undertaken of the Delivery Plan that will accompany the final Strategy.

Rather than respond to the consultation questions in turn, this response makes a number of comments in relation to each section of the Strategy and a series of recommendations. It also includes sections relating to certain socio-economic determinants which have a particular impact on the health of BAME communities, namely community cohesion, criminal justice and serious youth and gang-related violence including sexual violence, which this Strategy should address. We have included a level of detail about such and other issues which we are aware may be too much for this Strategy, but which we hope will inform its Delivery Plan. We would welcome the opportunity to continue to support GLA staff on this work given that health was identified by respondents to our 2009 consultation with the BAME VCS as one of their top five policy priorities.

[18] MacPherson, W. (1999) *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William MacPherson of Cluny.* The Stationary Office.
[19] Greater London authority (2009) *The State of Equality in London Report*

Recommendations

1. The Strategy should be developed based on the concept of substantive rather than formal equality by including targeted and specific action to address the health inequalities faced by BAME communities. Given the scale of such health inequalities, the Mayor should consider developing a Race Health Inequality Action Plan that is both separate from and integrated into the generic Delivery Action Plan that will accompany this Strategy.
2. The Mayor should reinstate the GLA equality and diversity team to ensure substantive equality is mainstreamed throughout its policies and compliance with equalities legislation.
3. The leader of the London Assembly should be assigned an equalities remit.
4. A thorough Equality Impact Assessment of the Health Inequalities Strategy must be undertaken in order to ensure compliance with the Race Relations Amendment Act (2000).

4. Objective 1: Empowering individuals and communities

We are very pleased with this objective which demonstrates the Mayor's belief that "all Londoners should be able to influence decisions that impact on their well-being and that diverse methods of engagement are needed if this is to happen". However, this section needs to be developed further to ensure it benefits BAME communities. The considerable investment over recent years aimed at giving local communities more influence has not adequately benefited BAME communities who remain excluded as evidenced by much of ROTA's work, for example:

- ROTA's Building Bridges and Female Voices in Violence Projects on serious group offending have reported the under-engagement of BAME organisations in the development of relevant policy.
- ROTA's 2007 report[20] on the previous Mayor's Health Inequalities Strategy, and 2009 consultation on mental health[21] both found that BAME communities were not fully engaged in the development of health policies and services locally and regionally.

Others[22] have evidenced the under-representation of BAME communities in local democratic structures and processes. Additionally, ROTA has also generated anecdotal evidence the engagement of BAME organisations in Local Involvement Networks (LINks) is patchy across the boroughs.

[20] ROTA (2007) *Developing the Mayor's Health Inequality Strategy for London: Stakeholder Engagement on Race Equality. Event repor*t

[21] ROTA/BEAM-EM (October 2009) *Consultation on New Horizons: Towards a shared vision for mental health*

[22] For example, 'Voice 4 Change England (2007) *Bridge the Gap: What is known about the BME Third Sector in England*. Final report & appendices. Abridged version', which reviews a wide range of existing literature about the BAME sector, reports the under-representation of BAME communities in the development of policy that affects them at many levels and in many areas; Kalathil (2009), NHS Bradford and Airedale/UCLAN, 2009) reports Service users and carers from BME communities are not as involved as they would like to be in commissioning and service development processes and decision making; MiNet has conducted a survey which has evidenced patchy engagement of BAME communities in local democratic processes and structures across London boroughs.

Recommendations

5. The Strategy should explicitly acknowledge the barriers faced by BAME communities in engaging in decision-making and include specific actions to address the, for example, by using Mayor's relationship with PCTs and Local Authorities to influence the latter's practices on engaging and supporting marginalised groups.
6. ROTA's recommendations[23] about the Community Voices for Health Network should be taken on board to ensure BAME communities are meaningfully involved. Linked to this network, a BAME stakeholder group should be established to advise on the development of this Strategy's Delivery Plan and monitor its progress.

4.1 The voluntary and community sector

We are very pleased by the recognition of the key role the voluntary and community sector (VCS) play in working to address health inequalities; not only larger VCS organisations that are delivering public services, but also small community-based organisations. As well documented by ROTA[24] and others[25], BAME organisations have a unique and vital role to play in addressing the health inequalities by:

- Bridging the gap between BAME communities and generic services
- Providing services to meet needs that mainstream providers are either unaware of or do not have the expertise to address
- Empowering BAME communities and supporting their engagement in decision-making
- Representing BAME communities and informing policy development
- Tackling the wider socio-economic determinants of health
- Advocating on behalf of people suffering discrimination
- Engaging otherwise isolated communities and acting as bridges to other communities, and therefore in strengthening cohesion.

The findings from ROTA's FVV project, for example, highlight the critical role of BAME organisations in addressing a particular health inequality. FVV has found that the majority of girls and young women that have been victimised as a result of their gang association are unlikely to take up generic health services and are sceptical of the independence of Haven and Rape Crisis Centres from the state, questioning their ability to maintain confidentiality and are of the opinion that, as their experiences are gang-related, they will be reported to the police. There is a vital role for specialist BAME women's organisations to play here in both bringing such young women to generic services, and in supporting the services to develop the expertise needed to appropriately respond to the complex needs of these young women.

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[23] ROTA (2009) *Response to the Terms of Reference for the Community Voices for Health Network*. This response recommended that places should be reserved specifically for BAME organisations to ensure representation; and that those representing particularly marginalised communities, which are typically under-resourced themselves, are resourced to engage.

[24] For example see 'Nea, B. & Cox, D. (2008) *Gaps & solutions: Supporting London's equalities sectors.* HEAR. (HEAR is a London regional network that was hosted by ROTA at the time this report was produced).

[25] For example see 'Perry, J. & El-Hassan, A. A., Hact (2008) *More responsive public services. A guide to commissioning for refugee community organisations*. JRF; Delivering Race Equality Action Plan

A national study[26] found that a significant proportion of BAME organisations are already doing work on health (14% of BAME organisations provide health services, including mental health. Other main services provided include: advocacy and advice on, for example, immigration, legal issues, equal opportunities and anti-racism (17%); welfare and income support services (11%); housing and accommodation services (11%); and school-related education (11%)). As it has been estimated[27] that there are 5,000 BAME organisations in London, there is huge potential for the Mayor to meet his responsibilities race equality responsibilities in relation to health by working more supportively with the BAME VCS.

Despite its unique value, the BAME VCS is under-valued and under-supported. The general picture presented by existing regional and national research is that it remains relatively fragile, suffering from a substantial lack of capacity due to severe under-investment and access to adequate infrastructure support. Many organisations struggle to grow and develop and even to sustain their operations. They operate in an increasingly challenging environment. They are being disproportionately impacted on by the recession[28] and the move from grant making to commissioning, which is favouring large and more resilient mainstream VCS organisations. In addition, the sector has been faced by its own specific challenges, particularly:

- Government's cohesion policies (this response includes a separate section about cohesion policies later)
- The uncertainty of the continuity of support from Capacitybuilders for regional BAME networks, which are vital if the BAME VCS is to have any influence in regional and local policy development.
- The continued and persistent inequality faced by BAME people.

ROTA is deeply concerned that these challenges will prevent the BAME VCS engaging at a level necessary to make this Strategy truly successful.

Recommendation

7. The Mayor, through this Strategy and other means, should explicitly recognise the unique and vital role BAME organisations play in addressing inequality and strengthening cohesion. The Strategy and Delivery Plan should include points to ensure greater support and sustainable funding for the BAME sector by, for example, raising awareness about the BAME VCS among local statutory partners and encouraging them to develop inclusive commissioning and procurement practices.

[26] Chouhan, K., Lusane, C., (2004) *Black Voluntary and Community Sector funding: its impact on civic engagement and capacity building.* JRF
[27] MiNet (2008)
[28] 'MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector.* London: ROTA' and 'NEP (2008) *Supporting Equality Groups: An overview of support to the diverse third sector in England*. Women's Resource Centre'

4.2 Education

We are pleased to see the links made in this Strategy to education in recognition of its bearing on health, as one of the most important routes out of poverty and disadvantage. The Strategy should refer to and aim to address the unequal educational outcomes of BAME communities. At present, black Caribbean, mixed white and black Caribbean, Traveller Irish and Roma Gypsy children have, on average, attainment rates below the national average. Furthermore, black Caribbean, mixed white and black Caribbean and black African children are more likely to be permanently excluded from mainstream education, and for reasons that their white peers may not be excluded for. Black Caribbean and black African children are more likely to be placed in lower tiered classes and be entered into lower-tiered examination papers.[29] The state of competition in the education system has produced schools considered to be 'failing', allowing for wealthier parents to move into areas with schools at the top of league tables, leaving others behind at an unfair advantage. The success or failure of schools has also determined their funding and compounded disadvantage. Additionally, many BAME families particular those refugee and migrant families, face difficulties in navigating the British education system which impacts on the quality of education they receive.

All of the above has been confirmed by research conducted by ROTA over the past two decades. Our seminal book, Inclusive Schools, Inclusive Society[30] highlighted these issues as barriers to an inclusive education system, which offered equal chances to all BAME groups. It is concerning that 10 years on from its publication, both a recent ROTA consultation, and a workshop held at the sixth London Schools and the Black Child Conference, raised these as persistent concerns.

Recommendation

8. The Strategy should explicitly refer to and include measures to address the unequal educational outcomes for BAME communities and make stronger links to the Mayor's 'Time for Action' Strategy[31] and the work taking place under it.

Supplementary schools

Supplementary schools play a vital role within society in developing the education of children from diverse backgrounds, particularly those from BAME communities. The services provided by them range from the national curriculum at GCSE levels through to cultural studies and mother tongue and English language classes including ESOL. The benefits to London that supplementary schools provide include that of contributing to social cohesion, both within communities through fostering positive intergenerational relationships and between diverse communities, raising educational achievement levels and strengthening cultural and ethnic and British identities. Within Camden alone, for example, there are at least 16 supplementary schools run by Bangladeshi, Somali, African Caribbean, Kosovo/Albanian, Egyptian, Ethiopian and Russian, based in community halls, places of worship, temples, mosques, and mainstream schools.

Supplementary schools have unrecognised potential in addressing health inequalities. A recent report[32] identified that organisations which are least likely to be involved in health

[29] Department for Education and Skills (2006a) *Ethnicity and Education: The evidence on minority ethnic pupils aged 5 – 16*. London: DFES; Department for Education and Skills (2006b) *Permanent and Fixed Exclusions from Schools and Exclusion Appeals in England 2004/5*. London: DFES

[30] ROTA (1999) *Inclusive Schools, Inclusive Society*

[31] GLA (2008) *Time for Action: Equipping Young People for the Future and Preventing Violence*

activities are supplementary schools. It concludes that a targeted programme of delivery of health promotion activities in supplementary schools would help address health inequalities experienced by BAME communities. According to the 2001 census, 43% of children and young people in Westminster are from BAME backgrounds, with the majority of these attending supplementary schools at some stage of their childhood. Therefore, reaching out to those children through their schools has the potential to positively contribute to the health and wellbeing of those children and their families.[33]

Recommendation

9. The Strategy and its Delivery Plan should include measures aimed at recognising the potential of supplementary schools in addressing health inequalities.

5. Objective 2: Equitable access to high quality health and social care services

BAME communities continue to face significant barriers in accessing health services, and often do not until they have reach crises points. This issue needs explicit consideration within the Strategy. The following points summarize key issues identified through ROTA's recent health-related research projects and consultations:

- Frontline health services staff, psychological therapists, managers, team leaders and commissioners of health services lack awareness about equality and diversity issues and BAME communities. This is evident, for example, in the approach that is used to detain and section BAME people, as well as in the way they are stereotyped as 'aggressive', by healthcare providers.[34]
- BAME communities often experience both direct and indirect racial discrimination in accessing health and related services.[35] Some examples of direct discrimination given at a 2007 ROTA consultation event[36] include: emergency service personal refusing to go on to a Gypsies and Travellers site; receptionists in hospitals and health centres being abusive and disclosing personal information about refugees and migrants in front of other patients; social services and police not attending to domestic violence incidents taking place at Gypsies and Travellers sites; Gypsies and Travellers being excluded from full services due to their apparent transient status. Examples of indirect discrimination given at the same event include stereotyping and lack of response to special needs, for example relating to dietary requirements, clothing and bathing.
- Inequality in employment in the health service is resulting in a workforce that is not reflective of London's communities. Lack of diversity is particularly an issue at the more senior staffing and board levels.

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[32] City of Westminster, Westminster Health and Social Care Network, NHS Westminster. *Our Strategy for tackling health inequalities in Westminster 2009 – 2016*

[33] City of Westminster, Westminster Health and Social Care Network, NHS Westminster. *Our Strategy for tackling health inequalities in Westminster 2009 – 2016*

[34] ROTA (2007) *The visible and hidden dimensions of London's homelessness: A Black, Asian and minority ethnic account*

[35] ROTA (2007) *Developing the Mayor's Health Inequality Strategy for London: Stakeholder engagement on race equality. 12 October 2007. Event report*

[36] Ibid.

- Young people outside the formal education system, which include a disproportionate number of BAME young people, lack access to sufficient sexual health education programmes, especially girls attending pupil referral units in a significantly male-dominated environment.
- There is lack of awareness of and attention paid to the potential violent experiences of young BAME women and girls by sexual health services.
- Refugees and migrants face barriers in accessing health care because: they are unaware of their rights and entitlements and how to access services and healthcare professionals are confused about the rights and entitlements of refugees and migrants; and language barriers. There is a significant potential role for community interpreters, as opposed to translators, to act as advocates and provide more comprehensive services to vulnerable individuals.
- BAME people are disproportionately represented among London's homeless population, and are more likely to face more complex health problems and barriers in accessing health and related services.
- Advocacy (even more so than translation or interpretation services) is crucial if particularly marginalised BAME groups are to shape and obtain public services.[37]
- Violence against women disproportionately impacts on BAME women, largely because of the lack of support individuals receive prior to the violence occurring from health, social care and services such as housing and education, as well as the barriers to support following the experience of violence.
- Many BAME girls struggle to access services from CAMHS, which have a wider take up from BAME boys who are referred through youth offending teams (YOTs).

Additionally, there is a need to greater reference to human rights in relation to access to health and social care services. ROTA's 2007 submission to the Joint Committee on Human Rights on the human rights of older persons in healthcare highlighted high instances of human rights abuses of older BAME people.[38] There is a need for greater awareness by health care professionals of their legal human rights obligations. In addition, there is a need for greater awareness amongst those who face health inequalities of their human rights.

Recommendations

10. The Strategy should include measures that ensure the barriers BAME communities face in accessing health services, such as those identified above, are addressed.
11. The Strategy should follow up on the GLA's previous work, Health and Race Equality Appraisal of Local Area Agreements, which aimed to raise awareness of London Boroughs Race Equality Schemes
12. The GLA should support the Equality and Human Rights Commission in monitoring the compliance of health and related services with the Race Relations and Human Rights Acts and potentially a Single Equality Act which will extend the positive duties to all equality groups, including to externally procured services.
13. The Mayor should advocate for the continuation and roll-out of the Pacesetters programme.

[37] ROTA (2007) *Developing the Mayor's Health Inequalities Strategy*
[38] ROTA (2007) *Submission to the Joint Committee on Human Rights on the human rights of older persons in healthcare*.

14. The Mayor should include measures in the Strategy aimed at increasing awareness among healthcare providers in London of their obligations under the Human Rights Act and among those who experience health inequalities of their human rights.

5.1 Mental health

It is well documented by ROTA[39] that BAME people, and black Caribbean people in particular, fare worse under the mental health system. BAME people, especially from African and black Caribbean communities are: over-represented within and often follow more coercive pathways through to, the acute end of the mental health system, including referral from the criminal justice system; more likely to be pathologised; more likely to receive drug rather than talking therapies; and more likely to be over-medicated. Despite this, BAME communities are failing to access the community, primary and mental health promotion services that might break what a Sainsbury Centre report[40] has described as a 'Circle of Fear'.

Within the South Asian community, there is a lack of awareness about mental health issues and stigma which is preventing access to appropriate services. There is a need for a programme of education around mental health targeted at this community.

Recommendations

15. The Strategy should explicitly reference the particular mental health issues of BAME communities and include measures to address them. In doing this, drafters of the Strategy should refer to ROTA's recent response to the government's draft strategy on mental health[41]; the work by the Breaking the Circles of Fear Team at the Sainsbury Centre for Mental Health[42], which considered the business case for race equality in the mental health system; the work of the Afiya Trust, which specialises in the impact of mental health policy on BAME communities; and the Equality Impact Assessment of Improving Health, Supporting Justice[43], which ROTA was involved in developing.

5.2 Commissioning health and social care services

As alluded to earlier, many of the barriers BAME communities face in accessing health services could in part be addressed through commissioning BAME organisations to engage in the delivery of health services. However, ROTA and others[44] have found BAME organisations face significant barriers in engaging in commissioning. While some good work has been done to address these barriers, it is patchy[45]. There is a need for a coordinated and concentrated effort to ensure recommendations from existing work are taken up by commissioners. In particular, there is a need to address the lack of awareness among health commissioners about the potential of BAME organisations, and the lack of support to enable, particularly smaller BAME organisations to prepare for the requirements

[39] Most recently during the ROTA/BEAM-EM consultation about mental health and also in ROTA's submission to the Joint Committee on Human Rights on the human rights of older persons in healthcare in February 2007.
[40] Sainsbury Centre for Mental Health (2009) *Breaking the Circles of Fear*
[41] *New Horizons: Towards a shared vision for mental health*
[42] Sainsbury Centre for Mental Health (2006) *Costs of Race Inequality.*
[43] Department of Health (2009) *Equality Impact Assessment of Improving Health, Supporting Justice*
[44] For example see Kalathil, 2009, NHS Bradford and Airedale/UCLAN, 2009
[45] For example 'Perry, J. & El-Hassan, A (2008) *More responsive public services? A guide to commissioning migrant and refugee community organisations*. Joseph Rowntree Foundation'.

of 'World Class Commissioning'. Additionally, there is a need for more intensive support provided through infrastructure organisations in the VCS, including support to enable BAME organisations to demonstrate their impact more robustly.[46] As mentioned, BAME organisations often provide significant social impact when delivering services that larger mainstream organisations, which may be able to provide cheaper services, are not usually able to achieve.

We were pleased to note in the sub-section entitled 'Commissioning Health and Social Care' under Objective Two that the Mayor is committed to increasing rape crisis service provision. However, we are very concerned that Ealing Council is leading on this work, particularly given its approach in 2007 towards Southall Black Sisters, a BAME women's organisation that provides specialist domestic violence services in Ealing. Ealing Council failed to recognise why specialist services are necessary to meet the needs of vulnerable groups who are unlikely to take up generic services. Additionally, Ealing Council demonstrated lack of awareness of race equality by failing to conduct a proper equality impact assessment of its decision to withdraw SBS's funding. This was recognized by Lord Justice Moses who presided over this case whose judgment stated: "*Specialist services for a racial minority from a specialist source is anti-discriminator and furthers the objectives of equality and cohesion."*

Recommendations

16. The Strategy should allow for a programme of learning about the diverse VCS for health commissioners. Such work could build on the 2007/08 work by the Housing Associations' Charitable Trust (HACT) which worked with commissioners and refugee and migrant community organisations and produced a guide.[47] The Strategy should also draw a link with work highlighted in 'Partnership in Public Services: An action plan for VCS involvement'[48], which states that the government will "promote the use of social clauses in championing the social value that the VCS can create and enable innovative approaches to grow". The Strategy should recommend that commissioners always take into account the "social dividend" provided by BAME organisations.
17. The Strategy should support the engagement of the BAME VCS in the delivery of public services by including support around commissioning for smaller and less formal VCS organisations in the work of the London Teaching Health Network and by encouraging local statutory services providers to develop more inclusive commissioning practices.
18. GLA should encourage local and regional statutory partners to maintain grants programmes to support the key role identified within this Strategy for smaller VCS organisations, which make up the majority of the BAME VCS.

[46] London Funders and MiNet Open Space Meeting at City Hall, November 2009
[47] Perry, J. & El-Hassan, A (2008) *More responsive public services? A guide to commissioning migrant and refugee community organisations*. Joseph Rowntree Foundation
[48] Office of the Third Sector (2006) *Partnership in Public Services: An action plan for third sector involvement*

6. Objective 3: Reduce income inequalities and minimise the negative health consequences of relative poverty

BAME communities in London are disproportionately impacted by income inequality and poverty as well as the impact of poverty. ROTA's 2009 consultation of the BAME VCS identified poverty and deprivation as one of the sector's top five policy priorities. The Mayor's Economic Development Strategy provides a timely opportunity to begin developing responses to the specific income inequalities experienced by London's BAME communities. MiNet's[49] response to this Strategy, however, argued that it does not do enough to address these needs.

Recommendation

19. The Mayor should develop his draft Economic Development Strategy into one which is more responsive to the specific issues faced by BAME communities as detailed in MiNet's consultation response[50] and its 2008 report[51] on the recession.

7. Objective 4: Health, work and well-being

BAME communities also face unequal outcomes in terms of work, and face discrimination in the workplace. Even with further education qualifications BAME individuals often find entering and succeeding in certain employment fields more challenging than their white counterparts. Although, overall, the BAME employment rate has increased in recent years, it is still lower than average, particularly for some groups, with Pakistani and Bangladeshi women experiencing the lowest employment rates of all (25 per cent and 31 per cent) and the highest economic inactivity rates (69 per cent and 63 per cent).[52]

The specific barriers to employment are different for different BAME groups, and are further complicated when one considers working rights of refugees and/or asylum seekers, and the transferability of qualifications from overseas. Even for those organisations that have successful recruitment statistics for BAME representation, their records on retention and progression often demonstrate an inability to offer appropriate support for BAME staff.[53]

The recession too poses particular problems for BAME communities in terms of work. Many of the debates about it have focused on its impact on middle classes and those losing their jobs from financial sectors. Additionally, discussions have focused on the impact of the recession on businesses rather than communities. This is problematic has it has meant that responses are less likely to benefit BAME communities. Although there is often a belief that deprived areas will not suffer because there is a supposed culture of not working, this is dangerously misleading. Evidence, both historical and recent, puts this

[49] MiNet is London's only regional BAME network, hosted by ROTA, which works to strengthen the voice of the BAME Third Sector in the development of regional policy
[50] MiNet (2010) *Response to the Mayor of London's Draft Economic Development Strategy*
[51] MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector.* London: ROTA
[52] ROTA (2009) *Response to the Mayor of London's draft equality framework, 'Equal Life Chances for All*
[53] Ibid.

fallacy to rest, as Davies[54] notes even in areas with high claims of Job Seekers Allowance (JSA) the majority of people of working age are not claiming such an unemployment benefit. Moreover, in both the 1990/91 and 2008/09 recessions, unemployment increased most in the communities where there was high proportions of manufacturing workers, where people lived in rented homes and areas which already had high unemployment.[55] Such data is also supported by recent research carried out by Muriel and Sibieta[56], displaying the high concentration of impact in areas already deprived. This is problematic for BAME communities, who, in London are overrepresented in these communities. This is even more important when research has clearly stressed that unemployment rates for BAME people rises faster than average unemployment during recessions.[57] Additionally, Berthoud's study[58] leads him to predict, for example, that the proportion of Bangladeshi's and Pakistani's will rise by nearly seven per cent, concerning when 47 per cent are already unemployed.

Recommendation

20. The specific inequalities faced by BAME communities in terms of employment and the disproportionate impact of the recession on BAME communities should be explicitly referenced in this part of the Strategy and addressed in the Mayor's Economic Development Strategy.

8. Objective Five: Healthy Places

We are pleased with the references in the Strategy to the potential use of the planning system as a means of reducing health inequalities. ROTA's response to the draft London Plan has urged for it to be developed into a Strategy based on the principles of substantive equality, as currently it is not and, as a result, will not make significant progress against the widespread inequality in London. Additionally, our response to the London Plan has recommended stronger links to key deliverables within the Health Inequalities Strategy.

As mentioned earlier there are a number of social issues which impact exclusively or disproportionately on the health of BAME communities which are considered below. While we have included these issues, namely, community cohesion, the criminal justice system, serious youth and gang-related violence, including sexual violence, under 'Objective Five – Healthy Places', they need to be considered throughout the Strategy as there are implications in relation to each objective.

8.1 Community cohesion

Our consultation with London's BAME sector earlier this year identified considerable concerns about statutory policy around community cohesion. Given the numerous references to community cohesion within this and related GLA strategies, we feel it

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[54] Davies, M. (2008) *Eradicating child poverty: The role of key policy areas – The effects of discrimination on families in the fight to end poverty*. York: Joseph Rowntree Foundation

[55] Day, k. (2009) *Communities in Recession: The Reality in Four Neighbourhoods.* Joseph Rowntree Foundation

[56] Muriel, A. & Sibieta, I (2009). *Living Standards during Previous Recessions*. IFS Briefing Notes No. 85

[57] Smith, D. (1977). *Unemployment and Ethnic Minorities, PEP;* Jones, T. (1993) *Britain's Ethnic Minorities, Policy Fiscal Studies*; Berthoud, R. (2009). *Patterns of non-employment, and of disadvantage, in a recession*, ISER Working Paper No, 2009-23

[58] Berthoud, R. (2009). *Patterns of non-employment, and of disadvantage, in a recession*, ISER Working Paper No, 2009-23

important to flag these up. Those we have consulted generally agree with the Mayor's beliefs on the links between community empowerment, cohesion and health. However, the BAME sector has concerns that too often empowerment and cohesion objectives are pursued by statutory agencies at the expense of equality,[59] by ignoring diverse needs and undermining BAME organisations.

In particular, there has been concern about the recommendation by the Commission on Integration and Cohesion about cutting funds for 'single groups' and the impact this has had on funding available to the BAME sector. While Communities and Local Government's (CLG) draft Cohesion Guidance for Funders was withdrawn, it and subsequent CLG cohesion policies appear to have influenced the practice of many funders; the underlying assumption often appears to be that activities focused on particular communities are divisive. Such assumptions are unfounded and demonstrate a limited understanding of the nature of inequality, and its inextricable links to community cohesion.

Cohesion debates also appear to have created a false dichotomy between 'bonding' and 'bridging', misunderstanding that bonding for marginalised communities is usually a prerequisite to bridging as is well evidenced.[60] The researchers of a recent JRF report[61], for example, found that 'bridging' activities should not be at the expense of ensuring all communities have the resources to stand on an equal footing, and that the need for externally strengthening communities is a necessary first step towards building bridges to other communities. The former Mayor of London's draft refugee integration strategy[62], similarly, emphasized the need for refugee communities to 'bond' to enable them to fully participate in wider public and social life.

The case of SBS against Ealing last year, demonstrates how this debate can be misused by funders to justify funding cuts. While ROTA's research has not identified similar instances where cohesion objectives have been used to justify cuts for funding, it is finding that organisations are under pressure to provide more generic services, diverting attention away from the need they were initially set up to address, to the detriment of equality for BAME people. The plight of London's Race Equality Councils illustrate this; over the last two years seven have closed leaving only 13. Similarly the findings of reports[63] by Imkaan and the Women's Resource Centre provide evidence of the decimation of the BAME women's sector.

Those organisations that have changed their focus from race to general equality appear to be having more success in fundraising. While this broader remit is suitable for some types of work, pan-equalities organisations are unlikely to be able to develop the expertise, trust and focus needed to address the specific types of inequality faced by different groups.

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[59] See ROTA & HEAR (May 008) *Response to the CLG's consultation on 'Community cohesion Guidance for Funders'.*

[60] McGhee, D. (2003) *Moving to 'our' common ground: a critical examination of community cohesion discourse in twenty-first century Britain*. Sociological Review, 51, (3), 376-404

[61] Temple, B. & Moran, R. (February 2005) *Learning to live together: Developing communities with dispersed refugee people seeking asylum*. Joseph Rowntree Foundation

[62] Mayor of London (July 2007) *London Enriched: The Mayor's Draft Strategy for Refugee Integration in London*. Greater London Authority

[63] Imkaan (2008*) A Matter of Life and Death: theloss of specialist services for BAMER women and children experience violence*; Women's Resource Centre (2009) *Not just bread, but roses, too: Funding to the women's voluntary and community sector in England 2004 - 2007*.

ROTA's experience of hosting HEAR, the pan-London equalities network, until recently has demonstrated this.

The concerns raised hear echo the considerable response by BAME and other equality sectors to CLG's 2008 consultation on its proposed Cohesion Guidance for Funders.[64]

Recommendation

21. The Mayor should acknowledge the inextricable links between inequality and community tension, where it exists, as done so by Lord Justice Moses in his judgement on the Southall Black Sisters' case against Ealing Council in all his policies which relate to community cohesion.

> *"Cohesion is achieved by overcoming barriers. That may require the needs of ethnic minorities to be met in a particular and focussed way. The Southall Black Sisters illustrates that principle…There is no dichotomy between the promotion of equality and cohesion and the provision of specialist services to an ethnic minority…Specialist services for a racial minority from a specialist source is anti-discriminator and furthers the objectives of equality and cohesion."*
>
> **Lord Justice Moses in his judgement on the Southall Black Sisters court case**

8.2 Hate crime

We agree with the Mayor that "Feeling safe at home and in the community is fundamental for mental health and well-being" and that "Reducing crime and increasing community safety are top priorities for the Mayor". Many BAME communities live in fear in their homes and localities, which this Strategy does not acknowledge or address.

ROTA's research study[65] into hate crime and restorative justice identified that in 2006/7, "the most commonly reported hate crime in London was racist crime (9,976), followed by homophobic crime (1,184 incidents) and faith crimes (696 incidents)". While it is encouraging that such incidents are being reported to the police, this level of victimisation remains a concern. With the enforcement approach that is being taken in response to youth violence, and policy responses to terrorism, ROTA is concerned that faith in the criminal justice system will be questioned by BAME communities, and they will continue to be victimised without the support of state institutions.

Recommendation

22. This Strategy should explicitly consider how to address racist crime and influence the work of other relevant agencies to ensure efforts to address it are stepped up. ROTA hosts a regional Transformative Justice Forum[66], which is a cross-sector multi-agency forum that aims to address hate crime in London through the promotion of restorative justice techniques which GLA should encourage relevant partnership to engage with.

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[64] Communities and Local Government (2009) *Cohesion Guidance for Funders. Summary of Responses*
[65] ROTA (2008) *Addressing Hate Crime through Restorative Justice and cross sector partnerships: A London Study*
[66] To find out more please visit http://www.rota.org.uk/pages/TJP.aspx

8.2 Serious youth and gang-related violence, including sexual violence

There are also certain community safety issues which are detrimental to the health of BAME communities in particular which need to be addressed. One such area of particular concern to ROTA is serious youth and gang-related violence, which statistics demonstrate affect African Caribbean young people and young people born outside of the UK disproportionately, as both victims and perpetrators. The impact on the mental and physical health of all those associated has been the focus of two high-profile ROTA projects, Building Bridges and Female Voice in Violence, over the last four years. Asides from the physical harm caused by serious youth violence, the impact of bereavement, trauma, fear and anxiety of BAME young people and their families, is significant on their mental health. The impact is exacerbated because of the barriers BAME people face in accessing health and mental health services, as considered earlier. Those who have participated in ROTA's projects have called for increased support from BAME and grass-roots based organisations for those who have been affected.

As mentioned, our projects have found that females associated with gang violence are faced with the risk of sexual violence and exploitation, and are often left with sexual, health and mental health needs that are not addressed. Mothers of young people involved in serious youth violence have raised concerns for their mental health, and have called for the support of BAME and grass-roots based organisations to offer them support and guidance. These women and girls are currently being neglected by health and social care services. The impact of this health inequality extends beyond this particularly vulnerable group and well into future generations and should be considered within this Strategy in relation to Objective One, Two, Four and Five.

Recommendations

23. The Strategy must acknowledge that there are social issues which impact on the health of particular groups and not others, which require specific responses, and include measures to ensure they are addressed through the Strategy's Delivery Plan.
24. The Mayor should consider the recommendations from ROTA's Female Voices in Violence project which will report in February 2010. In particular, the GLA should work with ROTA to develop an appropriate multi-agency strategy to supporting women and girls who experience gang-related violence, including housing, health, social care, education and children's services and criminal justice agencies, which ensures that this issue is considered at local levels. Additionally, this Strategy should work through the implementation of the Time for Action sand The Way Forward strategies to see serious youth violence as a public health issue, and that the mental, physical and sexual health needs of those associated with and/or impacted by serious youth violence are met – in order to reduce offending rates and victimisation, increase confidence in statutory support and improve the rates of inclusion and empowerment amongst BAME young people.
25. This Strategy and the Mayor more generally should address concerns about the victimisation of BAME communities by law enforcement agencies and other parts of the criminal justice system.

8.3 Criminal justice

Those ROTA has consulted and the work of others[67] have expressed concern about the impact of the criminal justice system on the health and mental health of BAME communities.

A recent partnership publication by ROTA and Race for Justice states that "the most recent figures show that BME groups account for 26% of the prison population, even though they constitute only 9% of the overall population". This disproportionality does not relate to offending rates and BAME people experience inequalities at every stage of the criminal justice system. While changes may have been made within the criminal justice system, the statistics show that this is not improving the experiences of BAME communities.

The issue is even more acute in London where, although young black Londoners under 18 constitute 15% of the population, they "represent 37% of those stopped and searched, 31% of those accused of committing a crime, 26% of pre-court decisions, 49% of remand decisions, 43% of custodial decisions and 30% of those dealt with by Youth Offending Teams".[68]

The NHS is not yet providing adequate services for BAME people who come into the criminal justice system and are failing to provide those with mental health issues with the machinery necessary to divert them into suitable care on arrest or from court. There is too much diversion from criminal justice to psychiatry for BAME people without the actual benefit of them then receiving appropriate treatment and care. BAME women are even more over-represented within the criminal justice system, making 54% of the population of Holloway Prison, for example.[69] Acute mental health problems are more prevalent among BAME women, in particular those who were born abroad, than white women or BAME men. BAME women face a range of additional problems within a system that has been designed with men in mind and which is without any realistic chance of addressing the causes of their criminality. Yet the needs of BAME women are largely missing from any relevant research, literature and policy initiatives.

Recommendation

26. Given the severity and scale of the impact of the criminal justice system on BAME communities, it should be considered within the Strategy in relation to Objective One, Two, Four and Five. In particular, the Mayor should:
    - Seek to influence the delivery of health and social care services within prisons to ensure they are beneficial to BAME people.
    - Consider and engage with work taking place under the Department of Health's Action Plan on Offender Health[70]. This Plan draws together the recommendations from Lord Bradley's review[71] of people with mental health

[67] NACRO (2007) *Black communities, mental health and the criminal justice system*. At www.ohrn.nhs.uk/resource/policy/Nacroblackcommunities.pdf
[68] The Home Affairs Select Committee report on Young Black People and the Criminal Justice System (2007)
[69] HMP & YOI Holloway summary of SMART II analysis: October 2009
[70] To find out more please visit www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108606
[71] Rt Hon Lord Bradley (2007) *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*

and learning disabilities in the criminal justice system and the response to the consultation on the draft Improving Health, Supporting Justice Strategy[72]

- Support the recommendation from The Corston Report[73] for a "women-centred approach" to female offending.
- Link this Strategy with existing structures such as the health pathway of the London Resettlement Board and the Regional Offender Management Service.

27. This Strategy should take forward the recommendations from research by the Commission for Racial Equality on the health inequalities faced by BAME people in the prison system.

9. Cross-cutting objective: Knowledge and learning

We are pleased that under 'Knowledge and learning' the Mayor has committed to addressing the inadequacy of the data collected by statutory bodies about the health inequalities experienced by BAME communities. In particular, we are pleased that the GLA will "develop a well-being index for London so we can check the impact we are having on the real-life experience of Londoners" and that this work will focus on "improving the collection and use of equalities data to evaluate health impacts for different communities."

Some of the gaps in information about the health of BAME communities that were identified at a recent ROTA consultation event[74] were:

- The need for more comprehensive BAME categories to be used by mental health services when gathering data. The experiences of mainly white Eastern European migrants, for example, are almost wholly absent from official statistics and there is very little good quality research. The invisibility of these migrants was partially revealed by the first annual Count Me In census of mental health service users[75], which showed a substantial number of people within the system identified themselves as 'White Other' with a first language other than English.
- While the Count Me In census of mental health service users has improved the data available about how BAME communities experience mental health services, it does not give the full picture. There is an absence of research about the trigger factors for the mental health issues experienced by BAME communities. There is also still an absence of good qualitative data in the healthcare sector, which makes it difficult to monitor differences by ethnicity in the use of NHS services.
- Local services should be determined by local needs assessments which include all parts of the community and use data and information held by organisations representing marginalised communities. BAME organisations and communities are not always involved in assessing needs meaning that Joint Area Needs Assessments often provide only a partial picture. Even where generic VCS

[72] Department of Health (2007) *Improving health, supporting justice: a consultation*
[73] Baroness Corston (2007) *The Corston Report*: A *report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system*. Home Office
[74] ROTA/BEAM-EM (October 2009) *Consultation on New Horizons: Towards a shared vision for mental health*
[75] To find out more about the Count Me In census visit www.countmeinonline.co.uk.

organisations input into Joint Area Needs Assessments, BAME communities often do not feel they are well placed or informed to represent BAME issues.

- There is a need for research and monitoring of young BAME people in mental health institutions.
- There is a need for data about medical pathways for BAME people, for example, referrals by GPs to 'talking therapies'.

Recommendation

28. The commitment made in the Strategy to address gaps in information and data on health inequalities should be prioritized within the Delivery Plan, with a focus on BAME communities. This commitment should be reinforced with more robust targets and indicators that track progress by ethnicity.

9.1 VCS knowledge and data

We are very pleased that the knowledge held within VCS organisations is valued within the Strategy and that there are plans for it to be used more effectively. The BAME sector has access to knowledge and data that other organisations, even mainstream VCS organisations, generally do not.

Recommendation

29. The knowledge and data held by BAME organisations needs to be acknowledged as distinct from that held by generic VCS organisations and supported explicitly within this section. There is a lot of work already going on that is making better use of such knowledge and data, for example by the Joseph Rowntree Foundation and the Information Centre about Asylum Seekers and Refugees[76], which should be built on.
30. Work should take place under this part of the Strategy that evidences the value of BAME organisations in addressing health inequalities. Case-studies should be collected and disseminated to incentivize statutory agencies to work more supportively with them.

9.2 The list of potential monitoring indicators

Recommendations

31. All indicators should gather data which can be broken down by ethnic group, but also by other equality groups, to ensure understanding is developed about multiple-inequality. Additionally, data should be collected in relation to the particular health issues faced by BAME communities. Success should be judged, in part, by evidenced reductions in the health inequalities faced by BAME communities. The categories included under 'major killers' and 'long-term limiting illnesses' should include illnesses that only or disproportionately affect different ethnic groups. Drug consumption should be included under 'health related behaviours'. This field should also capture 'type of drug' consumption. Experiences of discrimination, hate-crime and other forms of abuse should be included under 'socio-economic variables'. The 'Social capital and psycho-social factors' category should include indicators about levels of social exclusion, for example, 'feeling included', 'feelings of isolation' and 'levels of participation' for example, as councillors, school governors etc. The 'Access to healthcare and health system' category should include indicators which

[76] http://www.icar.org.uk/1609/making-better-use/making-better-use-of-data-and-information.html.

capture data about pathways through the healthcare system, as well as the factors which lead to health issues.

9.3 Multiple-inequality

Much of ROTA's work has focused on social policy concerns whose impact is intensified due to multiple-disadvantage. For example, our report about homelessness[77] found that homeless refugee women, for example, face even more acute health issues as well as barriers in accessing appropriate health and related services than BAME men. Given the diversity of London's population, and the complexity of inequalities experienced, this Strategy provides an excellent opportunity for the Mayor to lead the way in developing understanding about and innovative strategic responses to multiple-inequalities in a world city. Yet, this opportunity is currently missed and as it stands.

Recommendation

32. The Strategy should include measures which address and enable learning about multiple-inequalities – that is the health circumstances of those who belong to more than one equalities group, such as for example older people.

10. Section about partners

Recommendation

33. The BAME sector should be explicitly listed as a key partner in the delivery of this strategy. Regional BAME infrastructure organisations, as well as frontline BAME organisations should be supported to engage.

Race on the Agenda

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[77] ROTA (2007) *The visible and hidden dimensions of London's homelessness: A Black, Asian and minority ethnic account*