Health Inequalities National Support Team

Offender Health

Reducing Health Inequalities through Improving the Health of Offenders

Includes Potential Key Actions (see Appendix 1)

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

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Description	This workbook is a diagnostic approach to analyse the approach to offender health in a local area. Through a series of questions and reference to evidence based interventions, it allows a group of local partners involved in working with offenders, to determine what would need to be done to reduce the inequalities in ealth of this group. It is one of a series of workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health..
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For Recipient's Use	

Offender Health Workbook

Contents

Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People's Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learning from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

The topic of this workbook – *Offender Health* -– was selected because it is known that this group experience poorer health than the general population. Research into

the health of offenders shows extreme levels of poor physical and mental health, and of risk-taking behaviours, amongst the offender and ex-offender population.

Those in contact with the Criminal Justice System (CJS) – like any excluded group – are entitled to an equivalent quality and range of healthcare as the general population, designed to increase effective uptake, tackle health inequalities and support socially excluded and vulnerable groups.

Moreover, there is an ideal opportunity to engage with offenders while they are within the CJS in a way that might be more difficult to achieve after release/discharge and resettlement.

This workbook seeks to explore the relationship between offender health, access to appropriate health services and treatments, ongoing management and appropriate sentencing according to health need, prevention of offending and reduction of re-offending. This is considered from two perspectives:

- In general terms, the *health and wellbeing of offenders*
- The *specific links* between the CJS and access to services, treatment, disease management and prevention interventions that are particularly geared to address the physical and mental health of offenders

- 'This workbook – which is recommended for use either to carry out a local stock-take or to run a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommendations are given as to possible appropriate workshop invitees.

Central to the HINST approach is a diagnostic framework – *Commissioning for Best Population Level Outcomes* (see p13), which focuses on evidence-based interventions that produce the best possible outcomes at population level. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, aiming for **optimal population level** outcomes that are fairly distributed.
The framework points to the following areas of consideration:

A CHALLENGE TO PROVIDERS

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public

11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

B POPULATION FOCUS

6. Known population needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self management

The workbook is made up of sets of detailed questions in the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to offender health** to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide.

The workbook signposts good practice and guidance where this may be helpful. Appendix 1 outlines potential key actions for successful interventions this area.

Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of each workbook is a diagnostic framework – Commissioning Services to Achieve Best Population Level Outcomes' (see p13). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbooks signpost good practice and guidance where this may be helpful.

The resource represented by this workbook can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and delivery passes to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service uses and patients, and as whole communities, in their own health and wellbeing and that of the wider community The workbook will support the newly emerging organisations and networks as an aid to understanding commissioning processes aiming for population level outcomes. Key processes that should significantly influence local commissioning priorities as part of the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

The workbook is designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency

savings of up to £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

Local facilitators and participants will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook – *A Generic Diagnostic Framework for Addressing Inequalities in Outcome from Evidence-based Interventions* – has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference

How to Use this Workbook – a guide for facilitators

This workbook provides a diagnostic, which can be used in three ways:

1. For taking stock of the set of alcohol interventions to check their potential for delivering optimal population level outcomes that are fairly distributed and will have an impact on inequalities in mortality
2. With a group of commissioners and providers to develop a systematic approach to commissioning and delivering the set of evidence based alcohol interventions using this stock take approach.
3. In a workshop setting as described below

If used in a workshop setting, the objective of the workbook is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced.

The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants**. **Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but the suggested minimal attendee list for this workbook is set out below:

Strategic

1. Stronger and Safer Communities Partnerships
2. Community Safety Partnerships
3. Magistrates Association
4. National Offender Management Service / Directors of Offender Management

Health and Social Care

5. Public health
6. Acute/Hospitals trust – admissions, A&E
7. Drug Action Team
8. Alcohol team

9. Mental health trust
10. Local commissioners of offender health, social care and mental health
11. Health and Social Care Forensic teams
    - Police Force/Forensic Medical Examiner
12. Social Care lead for learning disability

Police and Crime

13. Police
14. Crown Prosecution Service (CPS)
15. Defence solicitors representative (contact local Law Society)
16. Probation Trusts
17. Youth Offending Team
18. Fire and Rescue
19. Prison establishments
    - Prison Governor with lead responsibility for health
20. ASB Team (local authority)

Crime Specialists

21. Hate crime
22. Domestic violence coordinator
23. Sexual violence

Courts Service -

24. Magistrates Court
25. Crown Court

Protection

26. Women's refuge
27. Safeguarding Board

Voluntary, Community and Faith Sector

28. Nacro[1]
29. Victim Support[2]
30. Rape Crisis[3]

Where there is more than one organisation (for example, hospital trust) providing local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but are informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing – and finding solutions for – local issues.

The facilitator should be familiar with the workbook questions and the model described below, which aims for a population level perspective to be taken. It is suggested that facilitators introduce the participants to this model and approach. Following the introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and aims for all participants have an

[1] Nacro Park Place, 10-12 Lawn Lane, London SW8 1UD, tel. 0207 840 7200
[2] Victim Support website: http://www.victimsupport.org.uk/Contact%20us
[3] Rape Crisis: c/o WRSAC, PO Box 39, Bodmin, Cornwall PL31 1XF

opportunity to contribute at the beginning. Finish by working through each sections 1-12 of the model.

Group discussions about all of the questions in each section allow strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication contains a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

There are a set of 'potential key actions' in Appendix 1, that investigate areas of work that are likely to have the biggest impact on reducing health inequalities. They will help services to be delivered in a way that is systematic, reducing variability and resulting in population level change. It is sensible to emphasise the related questions during the workshop.

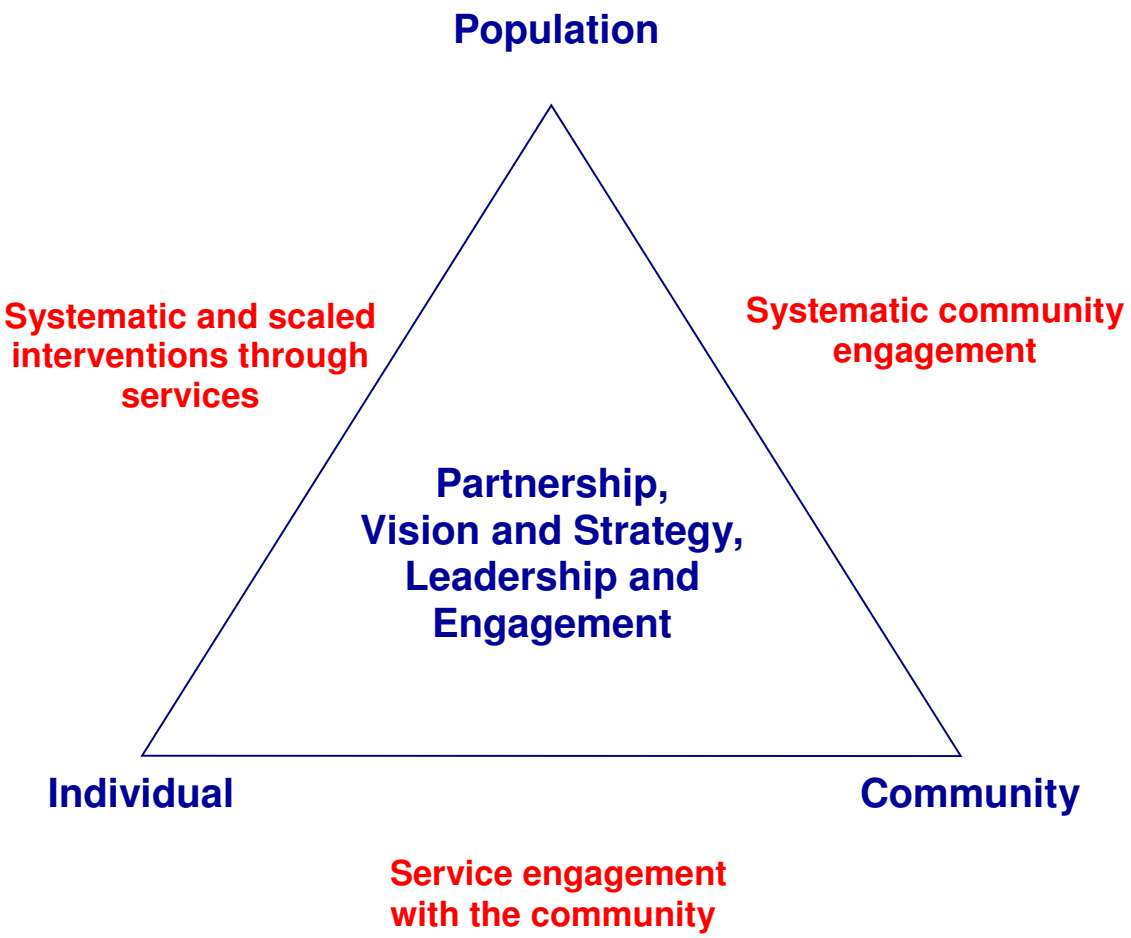
Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based –** concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated –** with measurements locally relevant and locally owned
- **Systematically applied –** not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately –** 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments')
- **Appropriately resourced –** refocusing on core budgets and services rather than short bursts of project funding
- **Persistent –** continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



Producing Percentage Change at Population evel

C. Bentley 2007

Population Approaches
Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

Individual Approaches through Services
Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to scale up the results within the available resources from individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any personal characteristics/sub-population group status or socio-economic status

and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

Community Approaches
Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

Commissioning Services to Achieve Best Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on page 14 with the title 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

The right hand side of the diagram (1 to 5) – a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

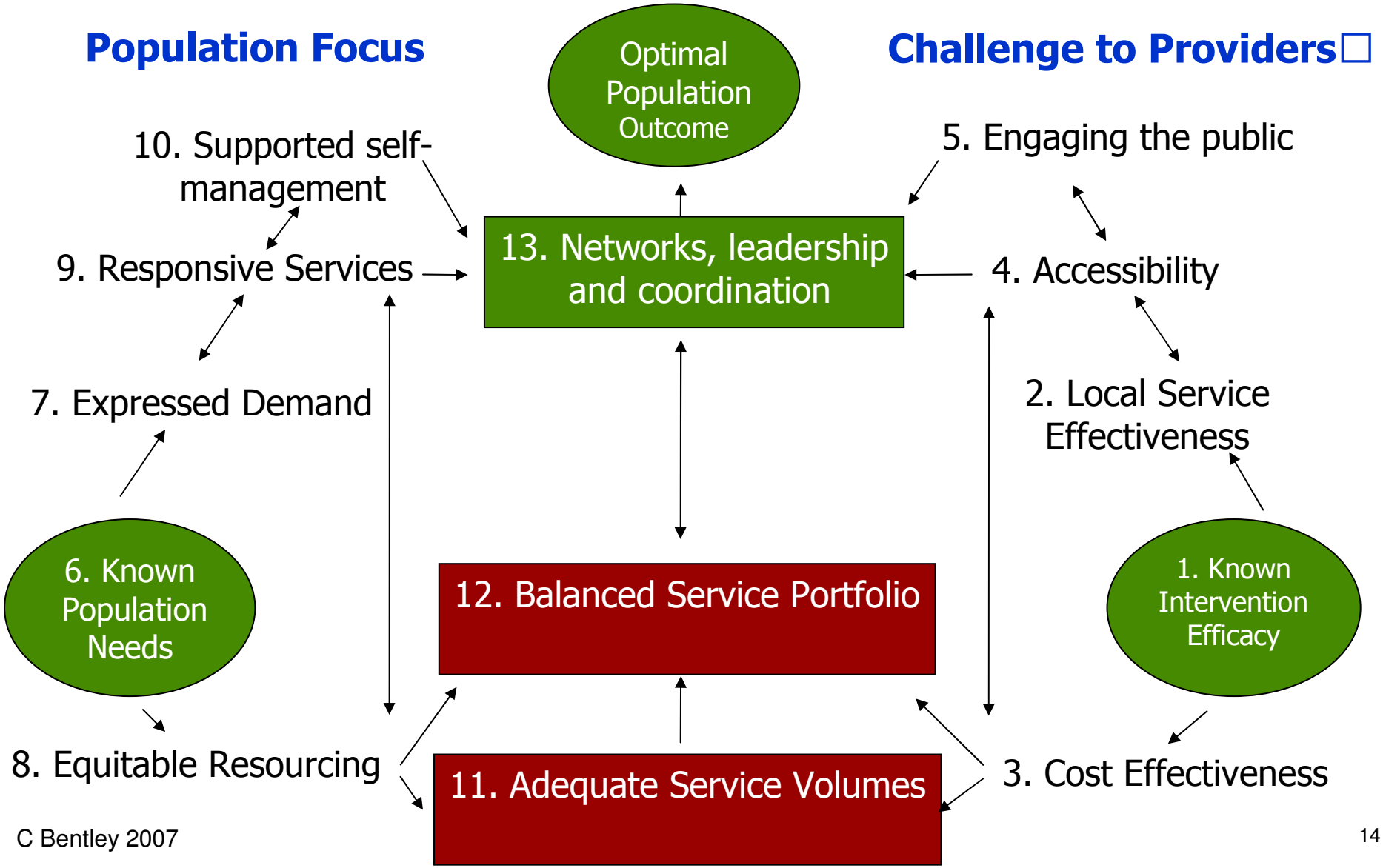
However, optimal outcomes *at population level* will not be obtained without the following:

The left hand side of the diagram (6 to 10) – a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram – the commissioning challenge: Aiming for equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider that what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help make sure that all services are effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with making sure that when the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks are needed to keep all these elements under review to gain continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.

2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level

4. **Accessibility:** Aim for services are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

5. **Engaging the Public:** Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that make the services acceptable to service users

B POPULATION FOCUS

6. **Known Population Needs:** Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

7. **Expressed Demand:** Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.

9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioners

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

> *(1) A public authority must, in the exercise of its functions, have due regard to the need to:*
>
> > *(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
> >
> > *(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
> >
> > *(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The Act identifies a number of "protected" population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of this legislation.

The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and the Public Health..
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.4

Useful Materials[5]

[4] The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010* http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

[5] *Making the difference – The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

Why this topic has been chosen

"Ill health has a detrimental impact on offending. It leads people into reoffending. Offenders face real health inequalities. They are often drawn from the most unhealthy sections of our communities."[6]

Offenders serving community sentences, prisoners and ex-offenders are a marginalised group who experience significant health inequalities. Attention to the issues affecting offenders is likely to bring about social benefits, including a reduction in re-offending, as well as health benefits in terms of health improvement and life expectancy. A reduction in re-offending is in itself likely to bring health benefits to a wider population. Moreover, there is an opportunity to engage with offenders while they are within the CJS in a way that might be more difficult to achieve after release/ discharge and resettlement.

All health commissioners and providers will have an offender population within their community regardless of a prison being in their area. Offender health is therefore an issue for all health commissioners and providers

A summary diagram of preventing youth offending and reducing re-offending is presented in appendix 2. The priority areas for reducing re-offending and improving health are summarised in appendix 3.

OFFENDER HEALTH AND EQUALITIES

Health and social inequalities

- Before custody, 58% of prisoners were unemployed, 47% were in debt[7].
- In terms of prison sentences below 12 months, 66% of those convicted are re-convicted within 12 months of release[8]
- The Social Exclusion Unit report *Reducing re-offending by ex-prisoners* in 2002[9] identified nine key factors the link between offending, re-offending and wider factors that influence offending and re-offending:
    - education;
    - employment;
    - drug and alcohol misuse;
    - mental and physical health;
    - attitudes and self-control;
    - institutionalisation and life skills;
    - housing;
    - financial support and debt; and
    - family networks.

[6] Catherine Hennessy, Director of Development and Partnership for Revolving Doors (http://www.idea.gov.uk/idk/core/page.do?pageId=17340394)
[7] CSIP/NHS West Midlands (2008) *Health Trainer Services in Prisons*
[8] www.idea.gov.uk
[9] Social Exclusion Unit (2002) *Reducing Re-offending by Ex-Prisoners*

Women

- As of July 2010, there were 4,279 women in custody in England and Wales. This is a reduction of 4% since July 2009. The main fall being reduction in numbers was within prisons. This is just over 55 of the total custody population[10]
- Two-thirds of the women who go to prison are on remand and more than half of them do not go on to receive a custodial sentence, with one in five acquitted[11].
- Between 1992 and 2002, there was a 196% increase in the number of women remanded to custody, compared to 52% for men[12]
- Half of all women on remand receive no visits from their family, compared with one in four men[11.]
- 40% (female) prisoners have a long-standing physical disability[12]
- 50% (female) prisoners have suffered abuse, a third physical, a third sexual and a third both [12]
- 20% of female prisoners ask to see a doctor or nurse every day[7]
- Female ex-offenders are 35.8 times more likely to commit suicide. The risk is especially high in the first month after release and for older ex-offenders [13].
- Women coming into prison had very poor physical, psychological and social health. Their health is worse than that of women in social class V, the group within the general population who have the poorest health. They reported being less active, having poorer nutrition and greater incidence of illness. 83% said they had a longstanding illness or disability. The most commonly reported problems were depression (56%), anxiety, and panic attacks (42%)[13].
- 90% of female prisoners have a mental health or substance misuse problem[12]
- Female prisoners have a higher proportion of psychotic illness or serious drug dependency compared to male prisoners[12].
- 50% of female prisoners have suffered abuse. Of this, 33% was physical, 33% sexual and 33% both. (This contributes to high levels of self-harm.) [12]
- 58% of women had used drugs daily in the six months before prison and 75% of women prisoners had taken an illicit drug in those six months. Crack cocaine, heroin, cannabis and benzodiazepines were the most widely used drugs[14].
- 42% of women prisoners drank alcohol in excess of government guidelines prior to imprisonment[14].
- Around 70% of women coming into custody require clinical detoxification compared with 50% of men[12].
- Around 600 pregnant prisoners receive antenatal care each year in England and Wales while in prison with recorded births of just over 125, yet there are only seven penal institutions in England with Mother and Baby units (Caring for Childbearing Prisoners Royal College of Midwives updated 2008)Units[14]

Women with mental health problems

- Women in custody are more than five times likely to have a mental health concern than women in the general population[14]

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[10] http://www.justice.gov.uk/pop-custody-july-10.pdf
[11] Corston J Baroness, (2007) *The Corston Report: A review of women with particular vulnerabilities in the Criminal Justice system Home Office*
[12] South East Regional Public Health Group (RPHG) (2008) *Public Health Factsheet Offender Health*
[13] University of Oxford, Department of Public Health (2007) referred to in the Corston Report (2007)
[14] Royal College of Midwives (2008) *Caring for Childbearing Prisoners*

- 78% of women exhibit some level of psychological disturbance when measured on reception into prison, compared with a figure of 15% for the general adult female population[14].
- 44% of women on remand have attempted suicide in their lifetimes; the comparable figure for men is 27%[11].
- Up to 80% of women in prison have diagnosable mental health problems[11].
- The Social Exclusion Unit found that 70% of women prisoners suffered from two or more mental disorders, 35 times the level in the general population[11].
- 66% of women in prison are assessed as having symptoms of neurotic disorders (depression, anxiety or phobias) compared with 20% in the general population[11].
- The ONS Survey of Psychiatric Morbidity among Prisoners in England and Wales carried out in 1997 on behalf of the Department of Health found 13% of the sample had schizophrenic or delusional disorders; this is at least 20 times the rate in the general population. Thirty-one per cent were assessed as having antisocial personality disorder; borderline personality disorder was found in 20%; and the next most common type was paranoid personality disorder (16%)[11].
- Women often have more complex poly substance misuse. Some are known to use up to nine different types of substances simultaneously and consequently need concurrent detoxification for alcohol, benzodiazepines and opiates. Nearly all are also heavy smokers[11].
- In 2003 women represented only 6% of the prison population but accounted for 15% of suicides[11].
- In 2005, notwithstanding the small number of women in prison compared with men, 56% of all recorded incidents of self-harm occurred in the female estate[11].
- 16% of women in prison (over 700) self-harm, compared with 3% of men[11].
- The prevalence of self-harming by hanging is very high in custody and is an extreme form of risky behaviour. Self-harm in the female estate has increased significantly in recent years. Many women in prison (16%) self-harm and for a small number of women it is a prolific activity[11].

Carers

Carers as offenders

- Over 50% (female) prisoners have a child under 16[12]
- Around two-thirds of women were mothers living with their children before they came into prison, one-third have a child under five[11].
- Only 9% of children are cared for by their fathers while their mothers are in prison[11].
- Around 18,000 children are separated from their mothers by imprisonment each year[11]
- Only 5% of women prisoners' children remain in their home once their mother has been sentenced to custody. As many as 25% are cared for by grandmothers; 29% by other family members or friends; 12% are in care or with foster parents or adopted [11].
- Revolving Doors Agency's survey in which 1,400 women serving their first sentence in Holloway were interviewed. 42 women had no idea who was looking after their children[11].
- Many women are imprisoned on minor charges, but only 5% of prisoners' children remained with other family at home during their mother's imprisonment.[12]

- More than half the women in prison have a child under 16; more than a third have a child under the age of five. At least a fifth of women in custody were lone parents before imprisonment[12].

Carers of Offenders[15]

Carers are an important part of the care of an offender. At any stage, carers can alert the police, the courts, lawyers and health professionals to concerns about someone's mental health, care and treatment. This is important when the person is vulnerable, affected by a mental disorder, presents a risk to themselves or others, or where there are concerns about the administration of medication. Carers may wish to keep in touch with healthcare and legal professionals and give their contact details.

Carers of people involved with legal or court proceedings share similar concerns with other carers, but can have additional ones:

- they or other family members may have been victims of the offender
- the nature or severity of the offence may have upset the carer
- carers can be stigmatised by the offence and have to move home
- the carer may be excluded from the legal process
- the person may not wish the carer to be involved with their healthcare
- forensic services are often regional and can be far away from the carer's home.

Carers may feel:

- ashamed or guilty about the offence or the challenging behaviour
- confused about the medical and legal systems
- worried about the long-term outcome for the person
- worried about financial matters and how to get help
- worried about the effect on themselves and the rest of the family
- worried about the circumstances in the hospital or prison.

People with Learning Disabilities[16]

People with a learning disability who are either accused of a crime or witnesses to a crime may be at a disadvantage within the criminal justice system as it stands. Factors such as their suggestibility, their ability to deal with questions or their decision-making can all mean that the process of obtaining justice can be more difficult for them.

- 10% of prisoners have learning disability[17]
- 7% of prisoners have an IQ of under 70[8]
- For young people in contact with the CJS[12]:
    - One in two young people known to the YOT are under-achieving in school.
    - One in three needs help with reading and writing.
    - 15 per cent have statements of special educational needs
    - 60% of juveniles screened during induction in custody were identified as having specific difficulties with speech, language and communication

[15] Taken from Royal College of Psychiatrists (2006) *Forensic Psychiatric Services, Working in partnership with psychiatrists and carers,* www.rcpsych.ac.uk

[16] Includes a wider range of autism spectrum disorders, dyslexia, and other indicators for Learning Disability (e.g. IQ below 70)

[17] www.nepho.org

- *No One Knows*[18] *r*esearch identified that people with learning disorders are relatively unrecognised within the CJS. This affects their ability to cope and to access important support that might reduce re-offending. Around 20-30% of offenders have learning difficulties or disabilities that interfere with their ability to cope with the CJS
- The research identified that if the person does not get the help and support they need, they are likely to understand less about, and receive worse treatment from, the justice system than other people who offend. Also, without the active engagement of health and social care, the factors that are linked to their offending are not likely to be met and consequently the risk of re-offending will remain high.
- At worst, people with learning disabilities and difficulties are not adequately identified as they enter the criminal justice system; they do not receive the support of an appropriate adult and don't fully understand what is happening to them. Some reported being maltreated by the police. They may also incriminate themselves during police questioning. Once in court, their lack of understanding grows as their lives are taken over by opaque court procedures and legalistic terminology. In prison, although most understand why they are there, the process by which they arrived frequently remains a mystery.
- Their inability to read and write very well, or at all, and poor verbal comprehension skills mean that they often don't know what is going on around them or what is expected of them. They spend more time alone than their peers and have fewer things to do. They will have less contact with family and friends. They experience high levels of depression and anxiety and often do not know what to do if they feel unwell. They are isolated and more vulnerable to ridicule and exploitation.
- Many will therefore be excluded from programmes to address their offending behaviour, which may result in longer stays in prison.
- In preparing for their release, prisoners with learning disabilities were more likely than their peers to say they had worries about leaving prison and that they thought they might come back. They were also less likely to say there was somebody to help them make plans for when they left prison. Many had high expectations of the kinds and extent of help they could expect from probation staff, to the point of being unrealistic.

People with mental health problems

- The 1998 publication of a survey for the Office for National Statistics on psychiatric morbidity among prisoners referred to in the Bradley Report[19] identified:
  - over 90% of prisoners had one or more of the five psychiatric disorders (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence)
  - remand prisoners had higher rates of mental disorder than sentenced prisoners
  - rates of neurotic disorder in remand and sentenced prisoners were much higher in women than in men.
- 9% of prisoners have severe and enduring mental health illness[18]
- 64% (male) and 50% (female) prisoners have personality disorder[12]

[18] Prison Reform Trust (2007) *No one knows: identifying and supporting prisoners with learning needs and learning disabilities: views of prison staff*

[19] Bradley, Rt. Hon. Lord (2009) *The Bradley Report: review of people with mental health problems or learning disabilities in the criminal justice system.* Department of Health

- In the first month after discharge, prisoners are 30 times more likely to die from suicide (than in the general population)[18]

Substance misuse
- 80% of prisoners smoke[18]
- 24% of prisoners with a drug problem are injecting drug users[18]. Of these:
  - 20% have hepatitis B
  - 30% have hepatitis C
- 63% (male) and 39% (female) prisoners are hazardous drinkers[12]

Physical health
- 33% (male) and 40% (female) prisoners have a long-standing physical disability[12]

Access to Health services
- On admission to prison, 40% of people deny contact with a GP and, on release, 50% of prisoners are not registered with a GP[20]
- 20% of female prisoners ask to see a doctor or nurse every day[7]
- There is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release[18]

Sexual health
- Rates of HIV infection are nearly five times higher among incarcerated men in the United States than in the general population, according to a 2002 study by the National Commission on Correctional Health Care, and AIDS is the second most frequent cause of death in US prisons. Rape may be a cause of HIV transmission among prisoners[21]. (No information was found in terms of statistics for the UK).
- No information was found in terms of whether inmates are permitted access to condoms.

Ethnicity
- BME groups are currently over-represented in the youth justice system and in the general CJS[12].
- An estimated 40% of the female prison population are foreign nationals[12].
- On 30th September 2007, there were 11,211 foreign nationals in prison establishments in England and Wales. This compares to 3,446 in 1993. The largest single group is Jamaican[12]
- In June 2006, members of BME groups accounted for 26% of the male prison population and 28% of the female population (including foreign nationals). For British nationals, the proportion of Black prisoners relative to the population was 7.3 per 1,000 population compared to 1.3 per 1,000 population for White persons. In contrast, people from Chinese or other ethnic backgrounds were least likely to be in prison with a rate of 0.4 per 1,000 population. The rate for people from Asian groups was higher than for White persons but lower than that for the Mixed or Black groups (i.e. 1.7 per 1,000 population) [12].

[20] CSIP (2008) Community Primary Care Access for Offenders in the West Midlands Region www.wmrdc.org.uk/silo/files/primary-care-access-exec-summary.pdf
[21] Altice F, Aspinger S, HIV in Correctable Facilities Chpt 14 in Clinical Practice in Correctional Medicine 2nd edition (2006) Mosby Elsevier

- 56% BME prisoners lived in the 44 most deprived local authority areas. These contained proportionately four times as many people from minority ethnic groups as other areas[12].

Faith groups – no information found

Lesbian, gay, bisexual and transgender (LGBT) people
The only "protective custody" available to lesbians, gays, bisexuals and transgender people in prison may be in segregated isolation. Lesbian, gay, bisexual and transgender people in prisons may face additional challenges as inmates and pose additional challenges for prison officials.

According to *Just Detention International*[22]
- 67% of all LGBT people report being assaulted while in prison, and LGBT inmates are "among the most vulnerable in the prison population". The vulnerability of incarcerated LGBT individuals has led some facilities to provide protective accommodation for such people, while in other facilities they are housed with the general population.
- Many LGBT inmates who are able, even those who are openly gay outside of prison, carefully hide their sexual identities while imprisoned, because inmates who are known or perceived as gay face "a very high risk of sexual abuse." LGBT people in prisons may face barriers in seeking basic and necessary medical treatment, exacerbated by the fact that prison health care staff are often not aware of or trained on how to address those needs.

Transgender issues[23]
According to Equality Law, with regard to accommodation in prison, it will be unlawful discrimination if a transgender suspect or offender is accommodated less favourably than non-transgender prisoners just because of their intention to undergo, or their actual, gender reassignment. This means that it will be necessary to treat a prisoner who decides to live permanently in their non-birth gender according to their chosen gender unless there is a compelling reason for doing otherwise. Only the accommodation of a transgender woman in a prison along with women and a transgender man in a prison along with men will allow them to live according to their chosen gender, equally to biological men or women.

Young people
Young people in the youth justice system can be vulnerable due to multiple problems and complicated lives. Custody can intensify this, by removing children and young people from their families, communities, and from mainstream and children's services.
- In 2004[12]:
  - 96,200 juvenile offenders were found guilty of offences
  - an additional 105,000 juveniles were given a caution/reprimand or final warning
  - 56,715 juveniles were sentenced to community sentences
  - 6,325 juveniles were sentenced to custody

[22] www.justdetention.org
[23] Boldt, Petra, Phillips, Chris (14 Dec 2010) *Some of the legal and practical implications for transgender people involved in the criminal justice system* http://www.journalonline.co.uk/Extras/1009076.aspx

- 27% of prisoners have been a 'looked after' child (2% of the general population) [12]
- Young offenders have an 18 fold increased rate of suicide in 15-17 year olds[12]

- Information on young people in custody[12] showed that:
  - 40% to 49% have been in local authority care at some point
  - 18% are still subject to care orders
  - 31% had mental health problems
  - 44.8% used more than one type of drug
  - 45.4% had been dependent on a substance
  - 40% of girls and 25% of boys reported suffering violence at home
  - 33% of girls and 5% of boys reported previous sexual abuse
  - 2/5 of girls and a quarter of boys suffer violence at home[8]

Older people

People aged over 60 is the fastest growing prisoner group[8]

Older people make up a smaller proportion of offenders but may have more severe health and social care needs[12]. It is known that they

- age up to 10 years more than their biological age whilst in prison
- are likely to have been in prison before (50%)
- are likely to have a long-standing chronic illness or disability (80%) and of these, more than 35% suffer from a cardiovascular disease more than 20% from a respiratory disease
- are likely to suffer from a mental disorder (50%) - mostly depression
- are often more vulnerable because they find it difficult to cope with the physical and mental stresses and demand of prison life.

A briefing by Jenny L Docherty[24] from the Prison Health Research Network (now the Offender Health Research Network) drew the following conclusions about older people in prison:

> *Prisons are designed for a young population with little or no attention to the particular needs of older people; for example, poor arrangements for people with limited mobility.*

A UK study[25] studied 203 men from 15 prisons, which held at least 10 older prisoners (over 60 years of age).

- 83% of older prisoners reported long standing illness or disability, 19% had a new illness that had started in the previous 3 months and 85% had a major illness or disability recorded in their medical notes. The sample of younger prisoners and older people in the community showed much reduced numbers.
- 10% of older prisoners interviewed suggested they were functionally disabled in 'Activities of Daily Living'. This is important in order to create an appropriate living environment and provide extra help if needed.
- The illnesses recorded were varied including: psychiatric 92%, cardiovascular 71%, musculoskeletal 48%, respiratory 31% and genitourinary 20%, endocrine 20%, and gastroenterological 20%. The level of self-reported illness was similar, with the

[24] Docherty J (2009) *Healthcare Challenges of Older People in Prisons – a briefing paper,* the Prison Health Research Network (now the Offender Health Research Network)

[25] Fazel S, Jacoby R (2002) "Psychiatric aspects of crime and the elderly. In: Jacoby R, Oppenheimer C eds. *Psychiatry in the elderly* [3rd ed]. Oxford: Oxford University Press. pp919–31

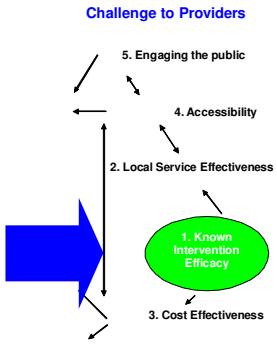
exception that only 18% considered they had a psychiatric illness and 88% thought they had musculoskeletal illness.
- Self-reported illness in the younger prisoners (aged 18-49 years) consisted mainly of musculoskeletal and respiratory illness.

In the same study, the management of chronic disease was found to be very variable in the prisons studied, for example:
- There was found to be a lack of promotion of hepatitis B vaccination.
- There was a distinct lack of medication review for those over 75 and a lack of communication from pharmacists.
- Prisoners were cold and the Government's highly publicised 'Keep well, keep warm' campaign was ignored by most prisons.
- Women prisoners were missing out on health screening for example mammography.
- The release of terminally ill prisoners is subject to very strict criteria and there were some good examples of palliative care found.

Bullying is endemic in prisons and the combination of old age and presumed offence (older prisoners are often assumed to be sex offenders) is enough to render older prisoners very vulnerable[26].

The Workbook

Reducing Health Inequalities through Improving the Health of Offenders



1. Known intervention efficacy

Looks for life saving interventions, for which there is strong evidence, being implemented equitably and made available to as many people who could benefit as possible.

1. Throughout the CJS (including custody)

- Are services designed by local stakeholders, including offenders and families, to respond to the needs of individuals and their families, responding to a changing population with access to services on the basis of choice?

- Are services configured in a range of different ways and with a range of different skill mix with a well trained, resourced and supported workforce working within and between the prison and community?

- Do networks and relationship that identify best practice and innovation research and knowledge exist for offender health?

2. Prevention and early intervention

- Is there a comprehensive range of prevention of offending and early intervention programmes? (See appendix 2 for examples.)

- Are the services for offenders of the same quality of care in comparison with the population as a whole and as a minimum, do they follow national guidance? For example:
  - Do health services adhere to NHS standards?
  - Do alcohol and drug misuse treatment services adhere to national guidance?
  - Are screening uptake levels similar to expectations for the rest of the country?
  - Do mental health services follow Bradley recommendations?

  Are they measured by clear health outcomes?

3. Court diversion and non-custodial

- Are diversion and liaison schemes effective in the area?

- Are offenders supported to access services (e.g. using non-stigmatising assertive outreach, patient tracking, identified support personnel and advocates)?

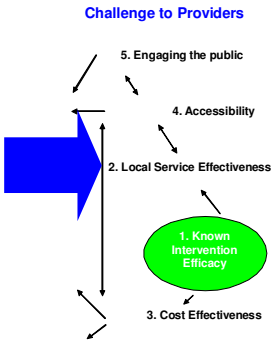
4. Release and resettlement

- Is there continuity of care as people pass through the criminal justice system and back into the community?

- Is there a systematic programme of resettlement that supports health and social needs?

5. Support for offenders with specialist needs

- Are there specific health care interventions and services - which are required for offenders and specifically for vulnerable groups who are offenders, identified? e.g. people with learning disabilities,



2. Local service effectiveness

Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

1. Throughout the CJS

- Do commissioners map and understand the strengths and weaknesses of the current service configurations and provision and re-commission or re-tender where gaps are identified?

- Are the expected standards, which relate to clinical care, improving the experiences of offenders and the development of staff providing the services, clearly set out?

- Have all the health services that work with offenders been registered?

- Is there a robust complaints system across all health service providers? Are these monitored and acted upon?

- Is there a robust performance management system which supports service delivery and enables regular communication with providers of services so that they deliver objectives agreed with partners? Are standards regularly reviewed and followed up if action needed?

- Is validated benchmarking data used and made available for providers to develop service standards and monitor performance?

2. Custodial settings

- What was the outcome of the recent CQC review of prison health care in the area?

- Is there a robust clinical governance structure in place in the prison, accountable to the local Partnership Board that includes drug treatment services?

- Is an effective Patient Advice and Liaison Service in place for prisoners?

- Are the performance indicators set out in Prison Health Performance and Quality Indicators[26] monitored?

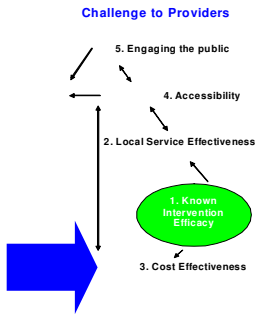
[26] Department of Health (2009) *Prison Health Performance and Quality Indicators*

- Do these include prisoners' healthcare during transfer and release and is there coordinated care across all relevant pathways?

3. Support for offenders with specialist needs

- Do all the staff working in the CJS receive appropriate training to support people with mental health problems, misuse drugs and/or alcohol or have a learning disability? Localised multi-agency training should cover as a minimum:
  - Recognising the symptoms and signs of someone with mental health problems or learning disabilities.
  - Recognising self harm and risk of suicide.
  - Case management of people with mental health problems or learning disabilities.

- Is there appropriate knowledge and skills training which includes the recognition of mental health problems in offenders and appropriate referral for people who are working with people with mental health problems?



3. Cost effectiveness

Aim for programme elements that are as affordable as possible at population level

1. Throughout the CJS

- Does the health commissioner have a good picture of how current investment in offender health is deployed and the levels of access that this provides?

- How does the commissioner know that this investment is being used effectively and efficiently to provide the best care and services? If it is not, are services re-tendered/decommissioned?

- Is cost benefit analysis used to analyse cost effectiveness – that is, to compare the cost of the current situation vs. a new service if it were to be introduced? Are qualitative benefits also analysed?

- Does this analysis include the likely savings in cost to the CJS and healthcare systems of:
  - crime prevention
  - comprehensive triage and assessment processes at police stations
  - shifting the health assessment and referral prior to custodial sentence
  - a different approach to commissioning and producing health and social care status reports and psychiatric court reports; including the positive impact on the CJS of reducing the average period spent in custody on remand.[27]
  - early identification of individuals with mental health problems who might receive a short custodial sentence but may also be eligible for, and receive, a community sentence
  - moving people to more appropriate settings i.e. a 'place of safety' - on arrest rather than police custody
  - appropriate referral processes from CSJ to health care settings
  - appropriate use of diversion schemes
  - the process of the management of people with mental health problems or have learning disabilities on arrest?

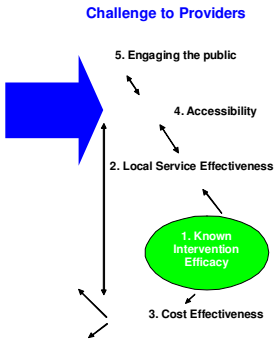
[27] Joseph & Potter study, described in Offender Health Research Network (2009) *Offender Health: Scoping Review and Research Priorities within the UK* aimed to reduce the frequency and length of custodial medical remands by providing a psychiatric assessment service at a magistrates' court. The scheme was successful in reducing the length of time spent in custody or avoiding it altogether. The benefits to the courts and the prison were considerable in reducing workload and making the procedure more efficient. For those acutely psychotic defendants were admitted directly to hospital, a lengthy remand in custody was avoided.

- Are there any Quality, Innovation Productivity and Prevention (QIPP) programmes in place which support offender health?

- Are opportunities taken to pool resources where this provides efficiencies and integrated planning and delivery? Are all partner agencies accountable for the full costs of offender management so that appropriate costs can be attributable across the system?

- Are there collaborations with existing services that increase access for offenders, minimise investment and result in changes in the pattern of delivery whilst mitigating the need for new services?

- By intervening early on in the criminal justice system, or even before people are arrested, it is possible to reduce both the costs to the taxpayer of those individuals going to court or to prison, and the cost of their health deteriorating further. Therefore, are the following prevention, early intervention and re-offending programmes in place:
  - Protective and preventative approaches to reduce re-offending, such as parent skill training; home visitation; drug misuse and alcohol prevention within the family, schools, community, general population and high risk groups?
  - Local Multi-systemic Therapy (MST) providing family and community-based treatment programme for young people with complex clinical, social and educational problems such as violent behaviour, drug abuse and school expulsion?
  - Local provision of preventive services by/involving the Youth Offending Team (YOT), such as
    - Youth Inclusion Programmes
    - Youth Inclusion and Support Panels
    - Mentors
    - Safer Schools Partnerships
    - Parenting Contracts/Orders
    - Acceptable Behaviour Contracts
    - Positive Futures?
  - Parenting skills and family therapy; programmes to promote relationship and life skills; maintenance of education; a local Family Nurse Partnership (FNP) providing intensive, nurse-led home visiting for vulnerable, first-time young parents; a local Family Intervention Project (FIP) aiming to reduce anti-social behaviour in the most challenging and anti-social families?
  - Court diversion and non-custodial sentences: that address risk factors – drugs and alcohol; primary care screening and 'brief interventions'; that promote protective factors - housing, work; restorative justice approaches?
  - 'Healthy Prisons', which includes: education and work skills; attitudes, skills and behaviour; nutrition, physical and mental activity; primary, dental and mental health care; drugs, alcohol treatment and anti-bullying policies; staff training and occupational health?
  - Care pathways including probation to provide support in relation to housing, employment and debt; integrated probation and mental health Care Programme Approach (CPA); continuation of drugs and alcohol treatment?



4. Accessibility

Aim for services are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

Those in contact with CJS, like any socially excluded group in the community are entitled to equality of access. Therefore:

1. Court diversion, non-custodial, release and resettlement

- Are services that meet the needs of offenders in the community located, advertised and provided in a variety of community settings including using voluntary, community and faith sector organisations to support delivery?

- Have commissioners developed integrated services with partners to enable better access to care in a variety of settings and eliminate service gaps?

- If 'approved premises' are provided in the locality, what is the range of health services provided in these premises?

2. Custodial settings

- What health services are provided within the prison? Do they include
  - general primary care
  - long term conditions (LTC) management
  - screening programmes
  - infectious disease treatment
  - sexual health
  - alcohol and substance misuse services
  - common mental health problems

- Are Healthy Prison Indicators adhered to?

- What broader health related prison services are available to deal with or promote:
  - education and work skills
  - attitudes, skills and behaviour
  - nutrition, physical and mental activity
  - anti-bullying policies
  - staff training and occupational health

- Does the prison design mitigate the negative impact of risks to health, and support emergency planning within prisons? For example, through planting of trees and providing open green areas to promote cooling during heatwave, reduce the risk of flooding and provide opportunity for physical activity.

- Primary care services in prison should be shaped for the specific needs of the prison population. Are the following characteristics found in the primary care services with the local prison?
  - services are comprehensive to the primary care needs of prisoners including: primary medical services, dentistry, ophthalmology and pharmacy; with referrals to services such as podiatry and physiotherapy when needed
  - an emphasis on improving health and wellbeing in addition to providing healthcare
  - a dedicated and appropriately skilled manager with systems in place to monitor quality of care.
  - a stable healthcare team that is receiving appropriate training and development
  - delivered through nurse-led clinics where this is appropriate
  - a strong emphasis on clinical audit and a healthcare team linked into local clinical audit and governance arrangements
  - provided on the same principles as those in the community and measured accordingly using the Quality Outcomes Framework
  - robust and effective links with primary care in the community aiming for continuity of care upon release
  - aimed to limit the need for prisoners to be transferred to hospitals for treatment through use of technologies such as tele-medicine and enhanced primary care services
  - good use of an IT system for management of the healthcare of the population.

- Is there good access to maternity services including ante and postnatal services?

- Is every opportunity taken to minimise need for offenders to leave the prison environment to receive care whilst maintaining cost effective services?

Support for offenders with specialist needs

3. Offenders with mental health problems and those with a dual diagnosis

- Are commissioners using the positive practice guide for Improving Access to Psychological Therapies (IAPT) for offenders?[28]

- Does the primary care team work closely with the in-reach team to meet the mental health needs of the population?

- Are there any local approved premises providing mental health/enhanced mental health services for mentally disordered offenders? If so, what level of service is provided?

- If there are separate drug courts and mental health courts, how do these deal with

[28] www.iapt.nhs.uk/wp-content/uploads/2009/02/83081-nhs-iapt-offenders.pdf

dual-diagnosis of mental health/substance misuse?

- Have there been any local instances of a mental health treatment requirement (MHTR) being initiated as part of a Community Order? Are these reviewed for appropriateness? If they have not been used, is there an understanding of why?[29]

- How is dual diagnosis of mental health and substance misuse problems dealt with in local prisons?

4. Offenders with learning disabilities

- Are the following elements part of the approach to work with offenders with a learning disability:
  - Are there general community services for people with learning disabilities that do not discriminate against clients who may have committed offences?
  - Do all staff working in the different agencies receive multi-agency training in learning disability awareness?
  - Do all agencies make every effort to assess/screen for learning disability?
  - Do agencies make reasonable adjustments to accommodate the needs of people with a learning disability?
  - Are assessments that are requested carried out and support given with a minimum of delay and in line with specified response times?
  - Are there strong links and information sharing with criminal justice mental health teams so that police, courts and probation services have the information they need to make the right decisions when necessary; and to enable compliance with care and treatment plans?
  - Does the service recognise its responsibilities under the Disability Discrimination Act and provide care accordingly in a non-discriminatory way recognising the rights of the individual?

5. Offenders who misuse drugs

- Do DAATs commission services from both NHS trusts and a range of non-statutory providers?

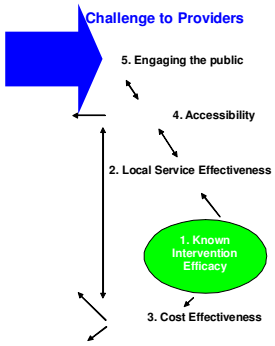
- Does the primary care team have shared care arrangements in place for conditions such as drug and alcohol misuse?

- Is there an Integrated Drug Treatment System (IDTS) that provides:
  - Care equivalent to that in the community
  - Coordinated case management approach (i.e. Drug Intervention Programme - DIP) that begins at first point of contact with the CJS and continues through custody, sentencing and through to resettlement

[29] If there are no instances, this might be related to:
- Insufficient training on the part of the Judiciary
- Insufficient training on the part of probation staff
- Resistance from solicitors
- Lack of a protocol for responsibilities for setting up and overseeing MHTRs
- Delay with obtaining medical assent
- A narrow band of appropriateness (i.e. an MHTR is appropriate for an offender whose mental condition is sufficient to require treatment, but not sufficient to warrant a Hospital Order or Guardianship Order under the Mental Health Acts 1983/2007)

- Integration of prescribing with psychological, medical and social interventions, if a patient has serious mental health problems, using an integration of services through a Care Programme Approach (CPA)
- Prevention of drug-related deaths on release
  - Pre-release referral to Community Drug Treatment Team (CDTT) through Prison Drug Worker
  - Pre-release registration with GP (including communication of discharge medication advice and follow-up)
  - Contingency arrangements if unanticipated release (e.g. direct referral to community drug treatment team)
- Greater integration of clinical and CARATs (Counselling, Assessment, Referral, Advice and Through care) services through the creation of multi-disciplinary systems
- Strengthened links to community and primary care services including health commissioners, DIPs, Criminal Justice Integrated Teams (CJITs) and drug treatment providers, aiming for continuity of care.

- Is there planning in place for the local commissioning of all prison drug treatment – CARATs, drug treatment budgets and compact-based drug testing?



5. Engaging the public

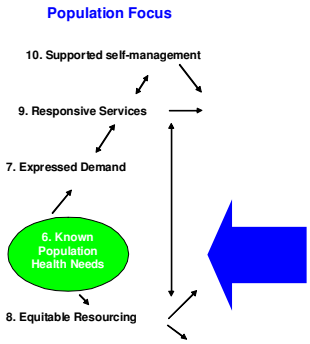
Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that make the services acceptable to service users

1. Throughout the CJS

- Is there a Community Safety Partnerships engagement strategy for offenders and their families?
- Do the health commissioners and healthcare providers have clear ways of engaging with the public, the local population and offenders and their families to understand their needs and service demand and to help shape services?
- What mechanisms exist (e.g. focus groups, surveys), which take into consideration the different needs of offenders to enable meaningful engagement?
- Are advocacy groups and/or voluntary groups and/or focus groups used to support service design and development?
- Do the health commissioners and service providers also consider alternative means of engagement with offenders (both in prison settings and the community) that go beyond traditional methods to build trust. Are third parties used to assist the process? For example, prison councils, engaging offenders' families through visitors centres and prison visits.
- Is information from voluntary, community and social enterprise organisations who work with offenders, whether explicitly or not, used to shape commissioning and service delivery?
- Are health trainers working in prison and with probation trusts to signpost and help people gain access to services? Do they act as advocates for individuals and a means of providing feedback to commissioners on health issues?

2. Custodial settings

- Do health commissioners with responsibility for prison healthcare have a Patient Advice and Liaison Service (PALS) that is accessible to prisoners? Do commissioners make sure that prisoners are advised how to make complaints and understand the role of PALS?
- As it is easier to engage offenders in custody than when in the community, is custody used as means of gathering views, not just for prison health services but also designing services for continuity of care upon release?



6. Known population needs

Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

1 Throughout the CJS

- Is there a local needs assessment, incorporated into the JSNA, which identifies the health needs of offenders and ex-offenders? Is this information broken down for each equality group including:
  - Their health
  - The proportion of these groups within the offender population
  - The effect of prison on their health and wellbeing, including disproportionately negative effects on particular groups?

- What data has been used in the needs assessment and strategy? (Examples of data can be found in appendix 4)

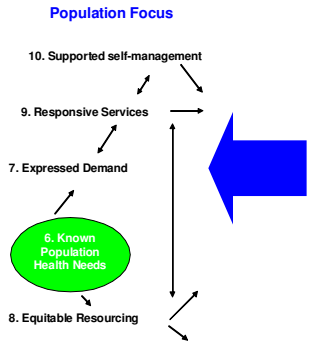
- Does the Community Safety Partnership undertake a shared strategic assessment and formulating a strategy to reduce re-offending?

- Do the health commissioners and partners translate the assessment into strategic objectives and commission to meet these objectives? Are there examples of service development and/or redesign that have taken place due to this needs assessment?

- Are areas of greatest need, poorest access to services and outcomes, mapped and identified?

- Are key data, intelligence and analysis shared within the partnership, with local people and potential providers?

- Is there a comprehensive map of local service provision, including lifestyle interventions provided by the public, private and voluntary and community sectors (VCS) which understand the needs of offenders?



7. Expressed demand

Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

1. Throughout the CJS

- Is every opportunity that an offender is in contact with the CJS exploited to understand the individual health needs of the individual so that they have access to appropriate treatment and ongoing management? How is this monitored? (See pathway in Appendix 5)

- Do criminal justice agencies help signpost offenders to services appropriately?

- Are services proactive in utilising resources such as assertive outreach, patient tracking and advocates, to enable offenders to access the services they need?

- Do the health commissioners invest in services such as health trainers and outreach or link workers to improve access and to help prevent people 'slipping through the net' of mainstream services?

- Is there a directory of services with information such as how to find and register with a GP or dentists willing to work with this group?

- Is there monitoring of usage of secondary care services (including A&E services) by this group and, where appropriate, action taken to improve services in primary care to address this?

- Are health and wellbeing educational materials and information on available services provided, that is appropriate for offenders?

- Is information shared appropriately, including integrated clinical information between providers of healthcare in the criminal justice and community settings via a single information system?

2. Custodial settings

- Is the first part of the first health screen (to identify quickly any immediate needs as someone enters prison - within 24 hours of first reception) effective in identifying any existing problems and in planning any subsequent care?

- Who undertakes this screen and are they adequately trained?
- Does this screening take place in an environment conducive for disclosure of sensitive information?
- Does the first screen include:
  - immediate physical health problems
  - immediate mental health problems
  - significant drug or alcohol misuse
  - risk of suicide and/or self-harm

- If immediate health needs are detected, is the prisoner referred to an appropriate healthcare worker or specialist team?

- In the week following first reception, is every prisoner routinely offered a general health assessment?
  - Is it done by an appropriately trained person?
  - Is this screening taken place in an environment conducive for disclosure of sensitive information?
  - Does this include:
    - gathering further medical information
    - checking how the prisoner is settling in
    - health education
    - providing information
    - health promotion?

- Is the police custody suite a sympathetic environment for disclosing health problems?

- Do custodial settings have an appropriate mix of staff to meet needs, including shared care and mental health?

- Are all agencies working in police custody (e.g. Appropriate Adults and Drug Intervention Programme [DIP] workers) receiving multi-agency training to raise awareness of health and its role in reducing re-offending.

- Does early health screening result in appropriate signposting to services and trigger requirements such as psychiatric reports?

- To what extent does the local NHS screen, treat and manage communicable diseases including the delivery of vaccinations programmes in prison?

- To what extent does the local NHS agree robust plans with prisons for the management of disease outbreaks such as flu and tuberculosis?

- To what extent is/are there:
  - nurse-led services in prisons providing a comprehensive sexual health service from screening through to treatment and advice
  - health promotion as a main strand of sexual health services in prison
  - information available for prisoners to promote better sexual health and safer sex
  - condoms available to the prison population?

3. Court diversion, non-custodial settings, release and resettlement

- Does the PCT work with probation to:
  - provide information and advice, thereby improving access to services
  - support offenders in gaining access to care through, for example, health trainers
  - improve GP registration in deprived and socially excluded communities

- Are local magistrates and Crown Court judges trained in the recognition of health /mental health problems and learning disability issues?

- Are community primary care services for offenders based on a robust assessment of health and social needs?
  - Are they provided in different settings to improve access for offenders?
  - Do they provide a more holistic approach to meeting needs through wider partner involvement such as social services, housing and, importantly, VCS providers?
  - Are they non-stigmatising, non-judgmental, and welcoming?

4. Release and resettlement

- Do those living in Approved Premises have access to all health services appropriate to their needs and to an equivalent standard to those enjoyed by the population as a whole?

- Are services such as primary care, mental health services, social care and specialist services accessible to those living in Approved Premises?

5. Support for offenders with specialist needs

- If a person is detained under Section 136 of the Mental Health Act 1983, is a mental health assessment made with minimal delay?

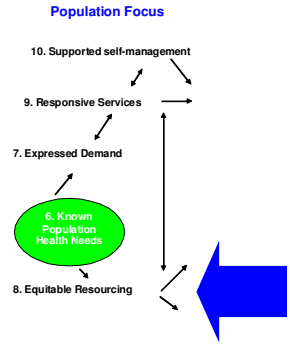
- Where is the designated 'place of safety'?

- Are people with a learning disability given access to an Appropriate Adult Service[30]?

- Are the prison in-reach team and prison healthcare team aware of the issues faced by people with learning disabilities and do they liaise with the Community Team for People with Learning Disabilities so that prisoners with learning disabilities gain appropriate assessment and support for their individual needs?

- Is awareness of learning disability training provided to at least one member of staff on each wing to support an effective liaison mechanisms to meet needs?

[30] Appropriate Adults can:
- provide support
- insist on legal representation
- explain what is happening to the suspect
- request a psychiatric and/or psychological assessment prior to interview to ensure the person is well enough to cope with the stresses.



8. Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need.

1. Throughout the CJS

- Does the commissioner have a good picture of how current investment in offender health is deployed and the levels of access that this provides?

- Does the offender health strategy address short, medium and long-term investment requirements?

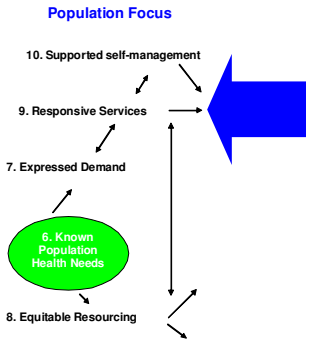
- Do any QIPP programmes focus on prevention of ill health and does healthcare management of offenders take into account the inequitable outcomes of offenders? Do budgets reflect disproportionate costs of achieving outcomes of disadvantaged groups?

- Have there been exercises to adjust provision of:
  - facilities
  - specialised staffing
  - outreach and community engagement staff

  in relation to mapped levels of need for, uptake of and use of services?

2. Custodial settings

- Given the concentration of need within prison, is there a higher the ratio of professional to patient for specific conditions within the prison setting than in the community?



9. Responsive services

When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

1. Throughout the CJS

- Is integrated care for offenders commissioned through a number of providers and different organisations with a clear-shared purpose and vision?

- Do service users experience a coherent and well-coordinated programme of care and have the support of a named key worker?

- Is the there a strong role for VCS agencies to provide valuable information and support the delivery of commissioning plans through providing new models of care?

- Is there a Health Trainers Programme (e.g. within the prison setting and/or in the probation service)? Do they have a role in referral to appropriate services within prison, on release and in the community?

2. Court diversion and liaison

Although many people may have been assessed during police custody, there will be offenders arriving at court with either mental health problems or a learning disability that require support through the criminal justice system or diversion into care settings.

- Do diversion and liaison schemes exist in the area?

- Do these schemes meet the Bradley report recommendations?[31]

- Do specialist courts exist (e.g. drug courts, domestic violence courts, mental health courts and community justice courts)?

[31] Bradley report recommendations are as follows:

- Larger teams performed better than smaller teams. In addition, teams that saw fewer than 100 clients a year never achieved an excellent score.
- Teams that operated on multiple sites were less likely to score 'limited' or 'weak' in all categories than court-only teams.
- Jointly-funded schemes outperformed schemes funded solely by health monies and rarely achieved any weak scores.
- An active steering group was an important quality assurance factor.
- A development plan was a good indicator of excellence.

- Do commissioners consider the specific needs of such courts in designing health support services?[32]

- Do the courts and services work together to increase the identification of mental illness or learning disabilities and facilitate and accelerate transfer to hospital where appropriate?

- Do the assessment schemes identify and assess people in order to assist magistrates with decisions concerning the offender, rather than whilst on remand in prison? Are clear expected outcomes for response to requests for assessment or reports set out in a service level agreement?

- Do liaison schemes successfully offer support and liaison for offenders with mental health problems linking them into appropriate community agencies and services including whilst in prison and on release?

- Do staff working in police custody and courts have mental health and learning disability awareness?

- Are there operational protocols in place to avoid confusion between parties; including dual diagnosis protocols as the overwhelming majority of clients are likely to have dual diagnosis, many with substance misuse as a primary diagnosis?

- Is there an information-sharing protocol between relevant agencies and a reporting structure into which collected data could be fed?

- Are there mentally disordered offender (MDO) panels that bring together a range of agencies – police, health, social care and probation – to put forward a coordinated package of care for the courts or Crown Prosecution Service (CPS) to consider?

- Do they co-opt other agencies and organisations, such as voluntary, community and faith sector organisations, housing services and drug services?

3. Release and resettlement

- Are offenders supported to maintain continuity of care from prison to community? What networks are created with other PCTs where offenders may settle?

- Is there a system that aims for offenders being registered with GP and attend a first appointment ?

[32] Information on the needs of people arriving at court is essential to:
- establishing whether they are fit to plead
- if they are not, whether a transfer to hospital is necessary; or, if they are, whether they will need support during the court proceedings
- determine whether they should be remanded to custody, bailed or transferred to hospital
- inform any decision that the magistrate or judge might make on sentencing options

- Are primary care services aware of wider needs of offenders and they able to signpost and refer (e.g. for housing, employment, benefits etc)?

- What are the local arrangements for:
  - Communication of information for continuity of care, with the prisoner's consent, to his or her GP and/or other responsible community agencies on discharge
  - help the prisoner by healthcare staff to to register with a GP prior to discharge, in cases where a prisoner who is receiving medical care that needs to continue after discharge and does not have an external GP
  - healthcare services in prison, where there is a clinical need, to make a referral to the local Community Mental Health Team
  - prisoners with disabilities or who are older, where needed, to have a community care assessment by the Social Services Department for the area in which they will be living on release?

- Are there links in the system with local Alcoholics Anonymous (AA), such as the AA Probation Link Scheme[33] ?

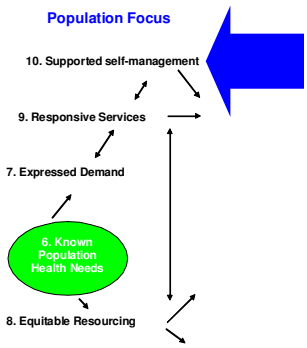
4. Prevention of re-offending

- What are the local incentives for organisations to prevent re-offending?

- Are there one stop shop initiatives to prevent re-offending that support offenders across the following nine key factors[34]:
  - _ education;
  - _ employment;
  - _ drug and alcohol misuse;
  - _ mental and physical health;
  - _ attitudes and self-control;
  - _ institutionalisation and life-skills;
  - _ housing;
  - _ financial support and debt; and
  - _ family networks?

[33] *Working with Alcohol Misusing Offenders*, was published in May 2006. "The Thames Valley Model" consists of the collation and publication of an Offender Manager (OM) AA Manual and delivery of training for OMs. Offender Management Units (OMUs) identify an AA Link Worker responsible for developing and maintaining links with local AA meeting networks.

[34] Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners*

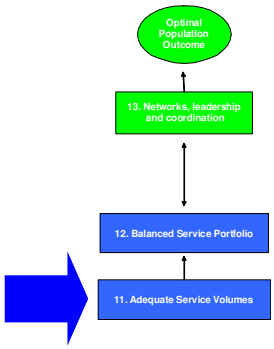


10. Supported self management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

1. Throughout the CJS

- Are there locally produced or 'kite marked' materials and support programmes available for offenders on self-managing their condition?
- Are good quality materials available in local 'minority' languages and adapted to 'minority' cultures?
- Are there support materials available for people with:
  - poor literacy
  - low IQ
  - poor vision?
- Has there been any 'segmentation' of education and support materials to reflect social marketing groups to understand the different needs of vulnerable groups?
- How are approaches that enable offenders to best self-manage their condition being systematised?
- What mechanisms are in place to check progress and maintained use of inputs by offenders?
- Are there graded follow-up supports available recognising variability in users' ability to self manage (e.g. available telephone helpline; telephone or text contact; intermittent face-to-face contact; frequent [domiciliary] contact)?
- How are systems of medicines management and patients adherence to therapy promoted? Is this based on active assessment and appropriate support based on cultural and language requirements?
- Are there local support groups for people with common problems? Do these cater for a variety of user preferences? Are they accessible where need is greatest?
- Is there a strong local presence from Specialist VCS providers? How do they integrate locally with public sector services?
- Is there a local Health Trainer Programme to support offenders with community sentences (and ex-offenders)? This would need to link into the Probation Service, and support lifestyle advice and access to services post release?



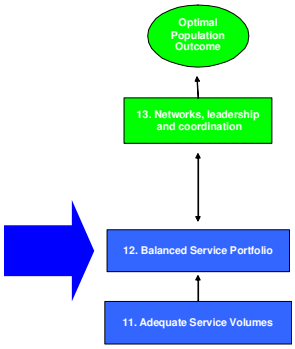
11. Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times.

1. Throughout the CJS

- Are service volumes sufficient to keep waiting times for access down to an acceptable maximum?

- Does the service capacity and management flexibility enable surges in demand to be accommodated?



12. Balanced service portfolio

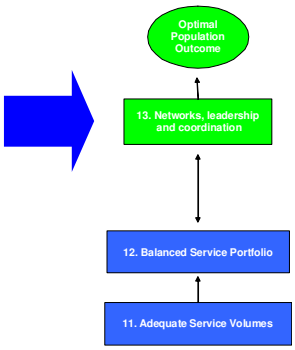
Aim for balance of services within pathways to avoid bottlenecks and delays

1 Throughout the CJS

- Is there sufficient capacity and efficient service management across the pathway of service, so there are no significant bottlenecks in the system?

- Are responsibilities for delivery of outputs and outcomes clear? Do these responsibilities extend across whole pathways?

- Are there routine, timely, information systems that allow detection of pressures in the system and initiation of effective corrective action? For example, psychiatric reports requested by the court; transfer of prisoners to hospital; support following 9 areas of re-offending on release. Do these systems include data sharing where appropriate across organisational divisions within a pathway



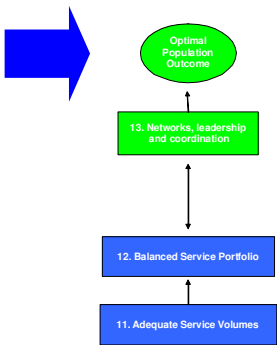
13. Networks, Leadership and Coordination

Designating leadership and co-ordination to aim for services are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

1. Throughout the CJS

- Is there a coherent and agreed partnership vision for offender health?
- Is there a community safety strategy that explicitly recognises the health needs of offenders? Are offenders considered as part of a wider strategy to support vulnerable groups?
- Does the health commissioner have a clear strategy and policy on the procurement of services for offenders?
- Do the local commissioning plans explicitly recognise the service requirements for offenders and ex-offenders including health and prevention re-offending services?
- What partnership arrangements are being used to commission and deliver offender health?
- Are the health commissioners effective and appropriately represented within these partnerships?
- Is there a Health and Wellbeing Board level champion for health inequalities who can advocate for socially excluded groups such as offenders and their families?
- Does the Health and Wellbeing Board receive regular reports on offender health performance?
- Is there a designated offender health lead?
- Are there identified clinical leaders who drive reform and improve life chances for offenders by working with partners in both commissioning and delivery of care services?
- How does the role of Prison Governor lead for health operate?
- Do all local leaders and partners understand the impact of improving offender health? Is there support to invest in quality services for vulnerable groups?
- Are there selected clinical, health and wellbeing outcomes that are desirable, achievable, measurable and align with partners' commissioning strategies for offenders?

- What support does the local Director of Public Health offer to health commissioners and NHS colleagues locally



Optimal Population Outcome

Aim for service outcomes that are meaningful locally, and drive the programme

1. Throughout the CJS

- Are clinical, health and wellbeing outcomes selected that are desirable, achievable, measurable and align with partners' commissioning strategy for offenders? For example:
  - Reducing level of self harm and suicide
  - Promoting healthier lifestyles
  - Reducing levels of addiction and harm form alcohol and drugs
  - Reducing the level of blood borne viruses
  - Improved sexual health
  - Improving care of LTC (e.g. diabetes)
  - Better access to care and continuity of care through the offender journey
  - Integrated delivery of services.
  - Supported resettlement

- Is effectiveness measured in relation to required outcomes?

Appendix 1: Health Inequalities National Support Team - Offender health: Proposed key actions

1. Commissioning of health and social care services for offenders and their families requires strong leadership and effective partnership working.

2. It is important that a local partnership strategy is agreed across the full spectrum of settings within the CJS including the prevention of offending and re-offending and include agreed health outcomes, such as improved health and wellbeing, living healthier lifestyles, better access to care and continuity of care through the offender journey and integrated delivery of services.

3. Provision of effective care services for offenders to:
   - deliver an equivalent standard of care to that available to the population as a whole
   - support socially excluded people (e.g. using non-stigmatising assertive outreach, patient tracking, identified support personnel and advocates)
   - enable continuity of care as people pass through the criminal justice system and back into the community supported by good information systems
   - identify the specific healthcare interventions and service functions required for the particular local socially excluded population and prison population
   - be designed locally to respond to the needs of individuals and their families, responding to a changing population with access to services on the basis of choice
   - be configured in a range of different ways with a wide skill mix and well trained, resourced and supported workforce working within and between the prison, criminal justice agencies and community
   - be appropriate and supported by best available evidence.

4. Awareness of, and training in, the recognition of and dealing with, physical and mental health issues, substance misuse and people with learning disabilities, is required for relevant workers, notably for the police, judiciary, and probation service. 'Appropriate Adults' needs to be available to provide support for people with learning disabilities in custody suites.

5. There would be benefit from increased focus on Health in the following specialist /problem-solving courts to deal with intransigent social and behavioural problems:
   - Drug courts
   - Domestic violence courts
   - Mental health courts
   - Community Justice courts
   - Offender Management and Control courts.

6. A Healthy Prisons[35] approach will:
   - put good health central to successful rehabilitation and resettlement
   - build physical mental and social health of prisoners (and where appropriate, staff) through a *Whole Prison Approach*

[35] Department of Health (2002) *Health Promoting Prisons: a shared approach*

- help prevent the deterioration of prisoners' health during, or because of, custody by building on the concept of *Decency*
- help prisoners adopt a healthy lifestyle that can be taken out into their communities
- create environments and initiatives which are supportive to health and improve access to services

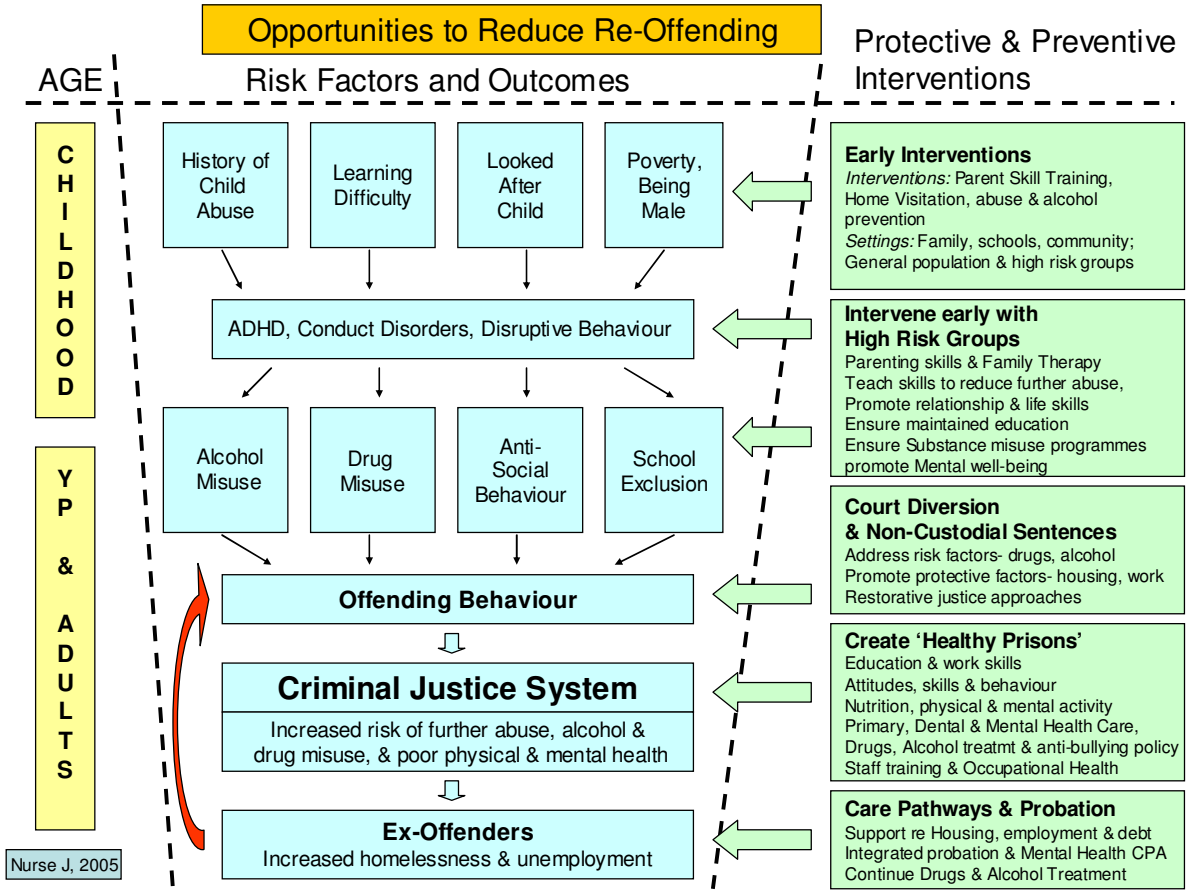
7. Health Trainer services for offenders will:
   - Provide support to offenders within a prison and community setting to access health services
   - Develop the public health workforce and the CJS workforce
   - Increase access to personal health support within prisons and advise on support services on leaving prison
   - Offer work based learning programme to assist interested prisoners to become health trainers
   - Assist prisoners in developing transferable skills when released into the general community
   - Influence and shape the range and breadth of lifestyle support services available within prisons

8. Adoption of procedures for reception, transfer and release which :
   - identify physical and mental health problems, indicators of recent substance abuse and the potential for self-harm
   - convey information on continuing care to other establishments on transfer and to NHS hospitals for outpatient and in/outpatient appointments
   - communicae information to support continuity of care, with the prisoner's consent, to their GP and/or other responsible community agencies on discharge
   - provide release support including access to support (e.g. housing, benefits advice, employment)
   - provide information on medication, appropriate to clinical need, so that supply is available until a GP prescription can be obtained
   - aims for transfers being made under s47 and s48 of the Mental Health Act for the transfer of prisoners to and from hospital, seeking to avert delays in both assessment and transfer, administrative difficulties, issues of lack of available beds, and over the appropriate level of security.

9. Aim to address issues of dual diagnosis through integrated working, and avoiding the worst possible situation where people with more serious mental health problems are excluded from substance misuse programmes and people with substance misuse problems are excluded from mental health treatment.

10. Routine provision of effective screening and health services in Approved Premises where there are high numbers of residents with physical and mental health problems, including heart problems, diabetes and mental illness (including depression and schizophrenia), and with a significant proportion of residents having previous or current illegal substance misuse or alcohol misuse problems. The development of enhanced mental health services are also beneficial for approved premises to deal with mentally disordered offenders.

Appendix 2: Summary Diagram of Preventing Youth Offending and Reducing Re-offending[12]



Appendix 3: Priority Areas for Reducing Re-offending and Improving Health [12]

Priority Areas	Actions
Early intervention	
Maternal mental health	• Treatment of MH disorders. Identify & treat maternal depression • Routine enquiries in pregnancy for domestic violence and mental health problems • Alcohol screening and brief interventions
Poor parenting	• Early intervention parenting skills training and family therapy. Promotion of relationship and life skills • Home visitation
Poor educational attainment	• Maintain education
Emotional health and wellbeing	• Emotional literacy programmes. School based programmes integrated with Extended Schools ○ Integrated MH promotion and substance misuse ○ Improve physical health (healthy diet, schools meals, increased water consumption and physical exercise) • Transition to Adulthood: 14 plus programme to aiming to introduce a person-centred statutory reviews in LAs
Early intervention with high risk groups	
Abuse	• Counselling and CBT for victims • Violence prevention and protection skills training. Professional training to identify and refer
Conduct disorders	• Parenting programmes for CD in children and for YOs • Community-based interventions for substance misuse in vulnerable young people • CBT/family interventions for psychosis
Parenting interventions for young offenders	• Parenting programmes for young offenders
Adolescent sex offenders	• DH exploring programmes to improve access psychological therapies • Victims of Violence and Abuse Prevention Programme (VVAPP) • Cross-Govt Strategy due on adolescent sex offenders
Learning Disabilities (LD)	• Integrated approach to services for children with LD and their families • Improve work of LD Partnership Boards • Training of families and those with LD for involvement in Boards
Court diversion and non-custodial sentencing	
Improve court assessment and diversion programmes	• Health and social care input into Neighbourhood Policing • Closer links between health and custody suites (Health Screening Tool) • Increase Courts' awareness of, and improve assessment with Diversion models that reduce numbers in custody needing NHS

Priority Areas	Actions
	care. (e.g. Offender Mental Health Care Pathway)
Address mental health problems of offenders and young offenders	• Early identification of problems and 'at risk' individuals • Address drug, substance and alcohol risk factors • Access to counselling and other MH services • Use of Onset, Asset & allied Youth Justice Board risk/need screening tools. • MH Transfer services to NHS facilities
Address vulnerable women and children	• Early identification of vulnerable women and use of alternative custody options for women and young people (e.g. women's centres and community solutions for non-violent female offenders and their children)
Create healthy prisons	
Healthy prisons	• Implementing smoke-free policy and addressing smoking cessation • Promoting positive mental activity (especially in remand prisoners) • Implementation of CPA, 'in reach' in prisons • Staff training in health and management
Female offenders	• Provision of appropriate support and counselling
Young offenders	• Implementation of the Comprehensive Health Assessment to the Young People's Secure Estate • Use of Onset, Asset & allied YJB risk/need screening tools • Treatment more aligned with Children's NSF
Offenders with LD	• Screening and assessment procedures prior to and on arrival. Adoption of person-centred or multi-disciplinary approach to improve access/referral to reducing offending opportunities. • Awareness raising of LD among staff
BME offenders	• Inclusion in Race/Diversity Action Plans
Older offenders	• Services integrated into mainstream health and social care service
Sexual health	• PCTs to work towards achieving green status on key performance indicators for sexual health. • Improve access to condoms, lubricant, chlamydia screening and other GUM and sexual health services. • Coordination of services between prison and primary care/ NHS • Improve access and orientation of services towards vulnerable groups recognising that offenders form part of these groups.
Communicable disease control	• Flu pandemic plans • Needle exchange throughout CJS pathway • Hepatitis prevention/vaccination programmes • TB services as NICE guidance (2006)[36]

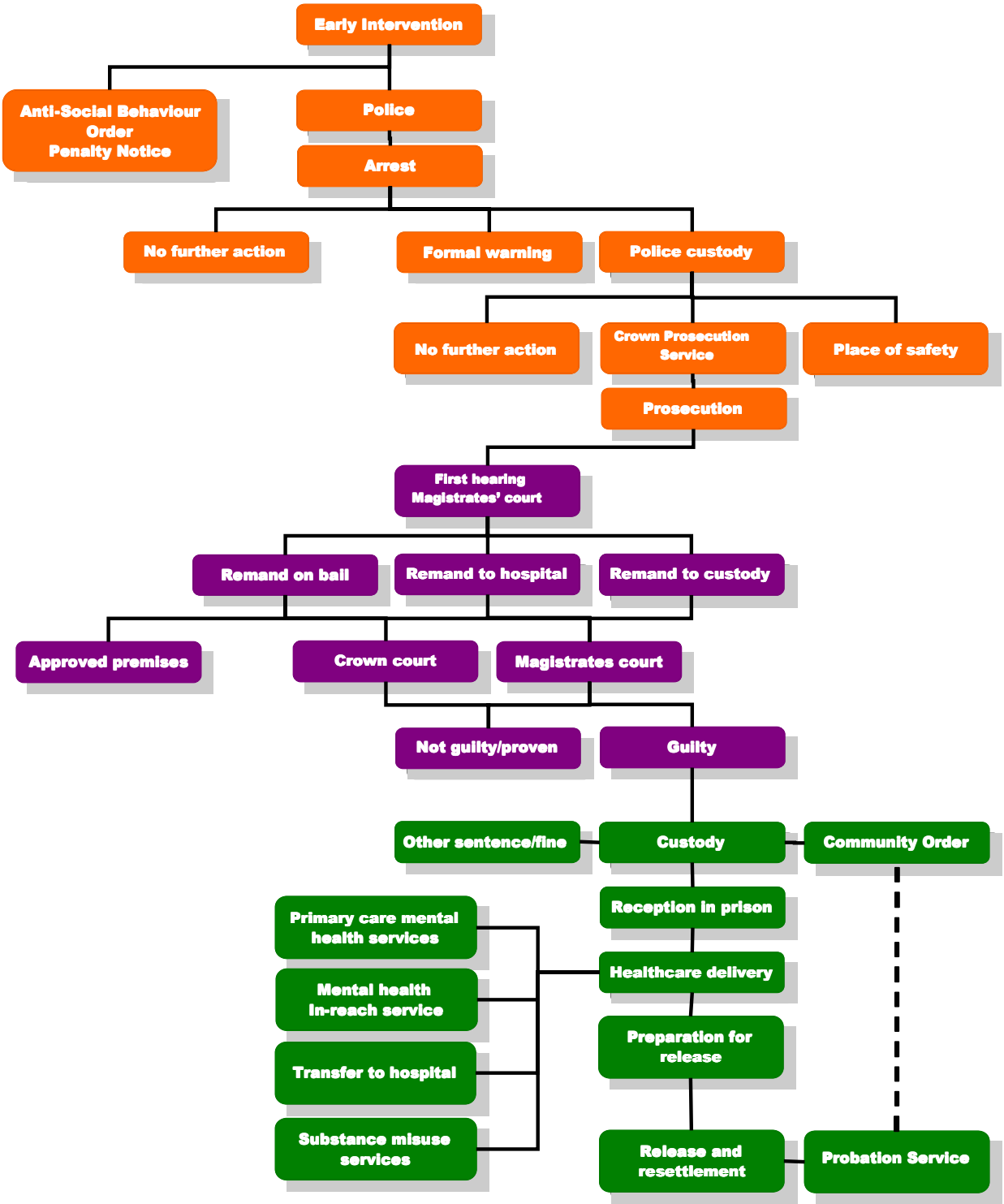
[36] www.nice.org.uk

Priority Areas	Actions
Care pathways and probation	
Mental health	• Appropriate and equivalent treatment across CJS pathway • Referral systems back to MH services on discharge from prison (especially for people with a serious mental illness)
Drug/substance misuse	• Integrated Drug Treatment Systems • Referral to high quality community-based services on release (key period for accidental death)
Alcohol misuse	• Screening and brief interventions provided at appropriate contact with CJS (e.g. arrest referral)
Social care	• Partnership approach to adult social care assessment and provision for older offenders, and those with LD
Education and training	• Offering more education, employment and training (EET) for all and especially socially excluded • Increase the priority of life skills in training and employment pathways
Access to health and wider social services	• Increased GP registration, access to Choosing Health projects and needle exchange throughout CJS pathway • Reducing linguistic /cultural barriers to services. • Increased availability of secure accommodation for socially excluded adults

Appendix 4: Examples of data sets

- **Accident and Emergency:** A&E records
- **Primary care**
- **Mental health trusts**
- **Social care**
- **Health visiting and midwives**
- **Public health observatories:** detailed analysis of issues for specific communities and geographic areas.
- **Substance misuse services:** DAATs and substance misuse services hold information that can be used to analyse need such as incidence of dual diagnosis amongst clients using services.
- **Neighbourhood policing and ASB teams:** local authority ASB teams, Police Community Support Officers and others involved in neighbourhood policing are aware of people who are becoming involved in crime but also those who are vulnerable to criminal or abusive activity
- **Police custody:** Police custody suites keep records of people who have been arrested who have health needs arising from self-harm or attempted suicide
- **Courts:** Courts hold information regarding the number of cases and types of cases, which also may help identify particular issues for commissioners.
- **Probation:** As part of their management of offenders in the community and on release from prison under licence, probation undertakes an analysis of needs of individual offenders using the Offender Assessment System (OASys) which examines criminal histories, risks of harm to others and themselves, and factors linked to each offender's offending behaviour. The OASys system should capture information on chronic health problems and disability, psychiatric and severe psychological problems, learning difficulties /low IQ as well as comprehensive information on drug and alcohol misuse.
- **Prison:** All commissioners with a prison in their area are required to undertake a regular health needs assessment of the prison population.
- **Housing:** Local authorities & housing associations - As well as information on excluded groups, there is a need to consider mobile populations including rough sleepers or people in short-term accommodation, which working with local homelessness organisations and traveller groups can help with.
- **Children's trusts:** can link strategically across education, social care and health which provide opportunity to contribute effectively to reducing re-offending. Poor educational attainment, truancy and exclusion are all significant factors in the profile of offenders that need to be considered by commissioners when developing plans to prevent people entering the criminal justice system.
- **Schools:** also can help identify children at risk through poor parenting or chaotic family lifestyles and behavioural issues. Early intervention can prevent more costly interventions at a later point.
- **Community opinion:** Information gathered as result of community engagement – focus groups, surveys, meetings

Appendix 5: Simplified Diagram of the Offender Pathway[12]



Appendix 6: Acronyms and Abbreviations

AA	Alcoholics Anonymous
A&E	Accident and emergency
ASB	Antisocial behaviour
BME	Black and minority ethnic
CARAT	Counselling, Assessment, Referral, Advice and Through care
CBT	Cognitive behavioural therapy
CD	Cognitive disorders
CDTT	Community Drug Treatment Team
CJIT	Criminal Justice Integrated Teams
CJS	Criminal Justice System
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CVS	Community and Voluntary Sector
DAAT	Drug and Alcohol Action Teams
DIP	Drug Intervention Programme
EET	Education, employment and training
FIP	Family Intervention Project
FNP	Family Nurse Partnership
GUM	Genitourinary medicine
HINST	Health Inequalities National Support Team
HMCS	HM Courts Service
IAPT	Improving Access to Psychological Therapies
IDTS	Integrated Drug Treatment System
JSNA	Joint Strategic Needs Assessment
LD	Learning disabilities
LTC	Long term conditions
MDO	Mentally disordered offender
MHTR	Mental health treatment requirement
MOJ	Ministry of Justice
MST	Multi-systemic Therapy
NSF	National Service Framework
OASys	Offender Assessment System
OM	Offender Manager
OMU	Offender Management Units
PALS	Patient Advice and Liaison Service
PCT	Primary care trust
QIPP	Quality, Innovation, Productivity and Prevention
VVAPP	Victims of Violence and Abuse Prevention Programme
YJB	Youth Justice Board
YO	Young offenders
YOT	Youth Offending Teams

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