DH Department of Health

Improving Health, Supporting Justice:

A Consultation Document

A strategy for improving health and social care services for people subject to the criminal justice system

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Contact Details	Offender Health Team Department of Health Wellington House, 133-155 Waterloo Road, London SE1 8UG
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MINISTRY OF JUSTICE

Home Office

Improving Health, Supporting Justice:

A Consultation Document

A strategy for improving health and social care services for people subject to the criminal justice system

Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

department for children, schools and families

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The Consultation Process

This consultation is being undertaken in accordance with an agreed Cabinet Office Code of Practice on Consultation, which is binding on UK departments and their agencies unless Ministers conclude that exceptional circumstances require a departure from it.

The Cabinet Office Code of Practice contains six criteria to follow:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what your proposals are, who may be affected, what questions are being asked and the time-scale for responses.

3. Ensure that your consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full text of the code of practice is on the Cabinet Office website at:

http://bre.berr.gov.uk/regulation/consultation/code/index.asp

Timetable for consultation

The consultation period will run from 27th November 2007 – 4th March 2008.

How to respond

This consultation seeks views on the proposed strategic direction and aims of the Offender Health and Social care Strategy, as set out in this document. Consultation questions are included in each chapter, and a response form can be downloaded from www.dh.gov.uk or by writing to us at the address below. An easy-read version is also available.

This consultation period began on 27th November 2007 and will run until 4th March 2008. Please ensure that your response reaches us by that date. If you would like further copies of this consultation document, it can be found at www.dh.gov.uk/consultations, or you can contact OffenderHealthMailbox@dh.gsi.gov.uk

Please send consultation responses by email to OffenderHealthMailbox@dh.gsi.gov.uk

Or by post to:

Offender Health c/o Mark Johnson
Department of Health Room 108
Wellington House
133–155 Waterloo Road
London SE1 8UG.

Offender Health will use the responses to this consultation in the development of the Offender Health and Social care strategy. The strategy will put forward a vision for the delivery of health and social care services for individuals who are subject to the criminal justice system.

When responding, please state whether you are responding as an individual or representing the views of an organisation. If responding on behalf of a larger organisation, please make it clear who the organisation represents and, where applicable, how the views of members were assembled.

We will publish a response to the consultation comments in April 2008. This will set out how comments will be incorporated into the final strategy, which will be published in June 2008.

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
2N16, Quarry House
Leeds
LS2 7UE

e-mail Mb-dh-consultations-coordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000, the Data Protection Act 1998 and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the Freedom of Information Act, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all cases.

Foreword

Improving the health and well-being of people in the criminal justice system is an important element of the reducing re-offending and health inequalities agendas. Many offenders, particularly with a history of persistent offending, have health and social care needs which may be causally linked to their offending behaviour. In addition, the proportion of this population with mental health needs is far higher than that found within the general community, and they are often associated with issues of drug and/or alcohol misuse and social exclusion.

We have already done much to improve services for those in prison: the transfer of commissioning responsibility for prison health services from the public sector prisons to the NHS was successfully completed in April 2006. Mainstreaming of prison health services commissioning with Primary Care Trusts (PCTs) has led to significant changes in understanding the health needs of prisoners and improvement of health services in prisons.

Looking at the wider criminal justice system, people have complex, multiple needs, requiring active and effective partnership working across the range of health, criminal justice and social care agencies. This will include those across the reducing re-offending pathways, such as education, accommodation and employment.

Many of the problems experienced by people with health and social care needs coming into contact with the CJS can be addressed by an improvement in partnership working and joint strategic development. This consultation will inform a cross-government strategy to promote a joined-up approach, based on partnership working. The strategy will guide a work programme designed to build on the progress made over the past few years with the reforms of prison health.

I know that many of you already have strong relationships with your local partners. We want the strategy to build on that, in addition to the learning gained from the transfer of prison services, the examples of good practice already developed by local partnerships, and to further capitalise on the key synergies between the health and criminal justice agendas. We want to ensure that the health needs of individuals, including women, children and young people, are met at all points of the criminal justice system.

This consultation provides a real opportunity to be a part of taking this agenda forward. I look forward to your responses, and to building the strategy with you over the coming year.

Ivan Lewis
Parliamentary under Secretary of State for Care Services

Introduction

Who we are, what we have done

Improving Health, Supporting Justice: A Consultation, is a joint initiative between the Department of Health, The Department for Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office. Between them, these three government departments have responsibility for health, social care and all the component services within the criminal justice system (police, courts, prisons and probation).

The publication of this document signals the start of a consultation process on how we can best work together to improve health and social care services for people subject to the criminal justice system.

Leading this work is Offender Health, a team which spans the DH and MOJ under Health and Offender Partnerships (HOPs), and works to improve the standard of health care for offenders across the CJS.

Offender Health is now broadening its remit to look at the needs of people in contact with the criminal justice system because they have committed, or are suspected of committing a criminal offence, with the aim of improving their health and well-being, addressing health inequalities, reducing re offending and crime and protecting the public.

Why do we need a national strategy?

What it's like now

Many offenders (particularly with a history of persistent offending) have particular health and social care needs which may be causally linked to their offending behaviour. The Social Exclusion Unit Reports "*Reducing Reoffending by ex-prisoners*" and "*Mental Health and Social Exclusion*" made a strong case for the links between the socially excluded population, offending, and poor health. The document also identified specific physical and mental health work streams as priorities.

People from black and minority ethnic backgrounds are over-represented in almost all the dimensions of social exclusion described above. It is no coincidence that people from some black and minority ethnic backgrounds are over-represented in the prison population.[1]

The proportion of offenders and ex-offenders with mental health needs is far higher than that found within the general community. This is also the case for children and young people in contact with the youth justice system. In addition, mental health needs in this population are often associated with issues of drug and/or alcohol misuse and social exclusion. Addressing these complex, multiple needs, requires active and effective partnership

[1] Reducing Reoffending by ex-prisoners; Social Exclusion Unit Report, July 2002

working across the range of health, criminal justice and social care agencies (a point highlighted in particular in relation to women in a recent study by the Dept of Public health at Oxford.[2]). The new Home Office Crime Strategy, *Cutting Crime: A New Partnership 2008-2011*, has its focus on drug misuse and alcohol misuse, responding to offenders with mental health needs and addressing social exclusion as well as reducing re-offending. The Strategy, emphasises the link between improving health and supporting justice, and will be a key driver of partnership work.

Prison Health has already shown how a high level formal partnership, supporting the development of strong local partnerships can be extremely effective.

Although there are numerous examples of good practice in the treatment and management of offenders and ex-offenders to be found in the community, these examples are often characterised by their individual nature. They often rely on the energy and enthusiasm of individual practitioners and there has been little evidence to date of a holistic approach to the care of offenders across the systems of health, social care and criminal justice.

The importance of partnership working across health, social care, education and criminal justice for children and young people in contact with the youth justice system has been recognised through the setting up of the Youth Offending Service. It is acknowledged that these partnerships need to continue to improve and develop. (eg 'Let's talk about it', Health care Commission 2006; Youth Justice, a Review of the Reformed Youth Justice System 2004).

The 2007 Comprehensive Spending Review saw the introduction of substantial changes to the Public Service Agreement (PSA) structure. The number of PSAs reduced from over 100 to just 30, each with up to five performance indicators and a identified 'lead department', with cross government contributions to the indicators reflected in published delivery agreements.

A number of the PSAs (DCSF) relating to children and young people will support a more co-ordinated approach to meeting the health and social care needs of children and young people in contact with the youth justice system:

- '**Increase the number of children and young people on the path to success**' will be supported by DCSF indicators in relation to improved transition between children and adult services; a reduction in the number of 16-18 year olds not in education, employment or training; and a reduction in the number of first time entrants to the criminal justice system, as well as a reduction in the use of illicit drugs.

- '**Improve the health and well being of children and young people**' will be supported by indicators including improved health and well being and securing and maintaining the provision of a comprehensive CAMHS service.

[2] The Health of Women in Prisons (2007), Study Findings, Dept of Public Health, Oxford

- '**Improve children and young people's safety**' will be supported by indicators of reduction in bullying and ensuring the safeguarding of young people in custodial settings.

The Home Office leads on PSA 25 '**Reduce the harm caused by alcohol and drugs**', to which the Ministry of Justice and Other Government Departments contribute, and delivery will be monitored through five performance indicators:

- The number of drug users recorded as being in effective treatment.
- The number of alcohol-related hospital admissions.
- The rate of drug-related offending.
- The percentage of the public who perceive drug use or dealing to be a problem in their area.
- The percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area.

These indicators will be used to drive a reduction in the harm caused to the community by alcohol and drugs, be these health or crime and disorder related. They will be supported by indicators housed within other PSAs that are crucial to reducing these harms:

a) Alcohol-related violent crime and disorder, especially assault with injury; the level of serious acquisitive crime; and the level of re-offending and serious re-offending which sit within the "**Make communities safer**" (Home Office) PSA.

b) The proportion of young people frequently using illicit drugs, alcohol or volatile substances that sits within the "**Increase the number of children and young people on the path to success**" (DCSF) PSA.

c) The recovery of criminal assets that sits within the "**Deliver a more effective, transparent and responsive Criminal Justice System for victims and the public**" PSA

The most important change is that for the first time we will have a cross-government alcohol and drugs PSA Delivery Agreement reflecting the fact that problem drug use and harmful alcohol use are public health and social issues and that they also have a significant impact on society, particularly deprived communities and vulnerable people, as well as contributing to offending.

The wider PSAs provide further opportunities to align priorities across government and through the delivery chain to support justice. Those particularly relevant to this agenda include **Making Communities Safer; Promoting Better Health and Well Being for All, Ensuring Better Care for All**, and Maximising Employment Opportunities for all, which makes specific reference to ex-offenders.

The new PSA's also set out changes for the performance management arrangements and reflects the development of the national indicator set for the Local Government Performance Framework, the new Health and Social Care Outcomes Framework, the Assessments of Policing and Community Safety, the National Offender Management Service's (NOMS) performance management

framework and the Youth Justice Board's performance management framework. The Home Office, other Government Departments and agencies are working closely together to ensure that these frameworks are aligned and can interface with each other in order to ensure that we minimise monitoring and reporting requirements on local partnerships.

Vision

Health and social care services will be designed to meet the challenging range of needs offenders and their families have.

These services focus upon social inclusion with enhanced access, assertive outreach and retention within care. Offenders and their families will receive standards of care equivalent to that of the wider community which are well resourced and their effectiveness measured.

How we would like it to be

Integrated, evidence-based services are delivered to help reduce social exclusion, and improve the health, well-being and rehabilitation of those coming into contact with the CJS in line with NHS and social care standards.

Effective aligned commissioning and partnership working with other statutory bodies e.g. probation trusts (boards) and Crime and Disorder Reduction Partnerships (CDRPs), non-statutory bodies such as Voluntary and Community Service organisations and Local Criminal Justice Boards (LCJBs) to deliver the most effective and timely interventions around offender health care services.

The continued development of Children's Trusts arrangements to support joint commissioning, pooled budgets and partnership working to promote the well being of children and young people, including those in contact with the youth justice system.

The mainstreaming of services is maximised and optimum use made of the opportunities presented by the criminal justice system to improve access.

Services are delivered to high standards and achieve best value for money.

Health and social care services in the CJS will be provided seamlessly with community based services, bridging the walls, with the benefits of critical mass of workforce, shared information, continuity of care, reduced professional isolation and retention in care.

The role of the third sector will be nationally and locally enhanced in helping to shape policy and design services.

Sensitive gender responsive services for women, taking into account the health and social care needs for women and their families.

Children and young people in contact with the youth justice system are well integrated into the wider Every Child Matters and Change for Children agenda, with account taken of their particular vulnerabilities and the need for extra support to engage them in mainstream services.

Services for both adults and children take account of the specific needs of older adolescents and young adults and the particular vulnerabilities of those young people in contact with the youth justice system and

ensure they are supported to make an effective transition between adult and children's services.

We aim to ensure that offenders irrespective of race, gender, disability, age, ethnicity, religion and sexuality secure the same access to health and social care services as the rest of the offending population.

Individuals will be empowered, with self-help and independence encouraged.

Improved assessment of offenders' mental healthcare needs (including the risk of self-injury or suicide, and substance misuse) and access to treatment, either during the criminal justice process, or, as appropriate and where the public protection risks are low, by diversion out of the criminal justice system.

Improved quality of data, records and information sharing in the interests of partnership working between agencies and across boundaries, promoting continuity of assessment throughout the Criminal Justice process.

Better integration of regional Offender Health work programmes within Government Offices and delivery in NHS and Social care.

Improved partnership working between CJS agencies and the NHS and social care, enabling effective and appropriate disposal/ treatment outcomes at every stage in the Criminal Justice process.

Challenges

Achieving these outcomes will mean collaborative partnership working between health and social care commissioners and providers with a range of criminal justice agencies in joint needs assessment, aligned commissioning, performance management and governance.

There are, however, some substantial delivery risks and challenges. The issues are often complex, cutting across organisation and service boundaries and potentially raising issues about prioritisation and resources.

We will consider any governance and risk management elements of the strategy depending on the outcome of the consultation and any cost assessment.

Following the transfer of health service commissioning in prisons to the NHS, PCTs are now starting to engage effectively where offenders are in custody. However it is difficult to identify offenders as a population group once in the community and there is no clear link between place of imprisonment and the offenders home.

Another challenge is the disparity between the CJS agencies, and also between the agencies and the NHS and social care organisations. Not only are there different organisational and geographic structures, but each organisation has their own funding streams and planning timetables. All of these issues can make integrated working difficult.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy or the Children and Young People's strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

How can organisations be better supported to work in partnership and integrate their planning and delivery of services, including through aligned commissioning?

How can we ensure that roles and responsibilities around offenders with mental health and/or substance misuse needs moving 'through the prison gate' are clearer, to prevent delays in accessing health services?

How can robust partnership work between health, social care, children's services and criminal justice agencies be promoted to ensure that targets and priorities are aligned more closely at regional and local level?

How can organisations better support gender specific services across the CJS?

How can organisations better support the integration of children in contact with the youth justice service into the wider Change for Children agenda, in relation both to access to universal services as well as to targeted preventive and early intervention services across health, education and social care?

Consultation questions (Continued)

How do we directly engage with offenders, to ensure our services are relevant and empowering?

How do we promote a vision for service provision in all health and social care communities but avoid being too prescriptive and preventing local communities designing their own approach?

Opportunities in Delivery

As well as providing challenges, looking at health and social care across the CJS will undoubtedly also provide opportunities. With the advent of cross-government commitments in the CSR announcement, organisations should be increasingly working towards the same key aims. Those of particular interest to this work include the following CSR07 PSA Delivery Agreements which play a vital role in galvanising public service delivery and driving major improvements in outcomes:

- Promote better health and well being for all
- Ensure better care for all
- Maximise employment opportunity for all
- Making communities safer
- Increase the proportion of socially excluded adults in settled accommodation and employment, education or training

The cross-government PSAs will be supported at the local level by the set of 198 national indicators and targets identified in Local Area Agreements. This provides a real opportunity

to put local delivery at the heart of the system to ensure that all partners are working together to tackle re-offending and the health inequalities faced by offenders and their families. From April 2008, LAs and PCTs will be under a duty to conduct a joint strategic needs assessment of the health and social care needs of their local community. The needs identified by this assessment will form the foundation for the ambitions for the place and its people set out in the Local Strategic Partnership's Sustainable Community Strategy. The new LAAs will be the delivery arm of the SCS and the primary lever through which Local Authorities and NOMS can engage local partners to reduce re-offending and tackle social exclusion. The indicators would provide local authorities, primary care trusts, local partnerships such as Children's Trusts, CDRPs and LCJBs, and probation trusts (boards) with a means to targeting services towards offenders as a tool to achieve equivalence for offenders in accessing resources within local services.

The creation of new public sector bodies, probation trusts, introduced by the Offender Management Act 2007, also provide an exciting opportunity to commission, joint commission and work in partnership to provide services to tackle health inequalities for offenders and to reduce re-offending. Probation trusts or the existing probation boards will perform a dual function. They will have responsibility for being the lead provider of offender management. But they will also be responsible for commissioning and joint commissioning interventions and other services from the best provider in the public, private or third sector. In supporting commissioning arrangements, probation trusts or the existing boards will have to consider how best to take forward partnership arrangements on behalf of NOMS and the reducing re-offending agenda.

But it is also important that we continue to use existing opportunities with local partnerships to improve offenders' access to health services in their local areas. Crime and Disorder Reduction Partnerships (CDRPs) are in an unique position to bring together and co-ordinate the actions of a range of partner agencies all which have a critical role to play in supporting the services to reduce re-offending. Primary Care Trusts as 'responsible authorities' within the CDRP have an important role in ensuring that offender health is considered as part of the joint strategic needs assessment that it carries out with the LA and given sufficient consideration by the CDRP and the LSP. The proposed changes within the local delivery landscape provide an opportunity for CDRPs and LCJBs to explore potential ways of joint working. Successfully rehabilitating and resettling offenders in the community will have a significant impact both on existing CDRPs' crime reduction targets and LCJBs' public confidence in the criminal justice system targets.

For children and young people it is important that we continue to develop and improve the opportunities within the Youth Offending Service partnerships, Children's Trusts and other partnership working in accordance with Every Child Matters to ensure children in contact with the youth justice service have their wider health and social care needs met.

The importance of partnership working for children and young people has also been recognised through the Every Child Matters/ Change for Children Agenda and the National Service Framework for Children Young People

and Maternity Services. To support this, all children's services, including youth justice services, are governed by the ECM outcomes framework which also informs the inspection framework for all these services.

Costing the Strategy

This consultation document seeks views on the opportunities for improving the health and social care of offenders. The opportunities outlined have not been subject to a full cost and benefit assessment. This will inform the development of the strategy for publication next summer. No new requirements will be placed on the NHS or social care without additional funding.

Co-ordinated Strategies

Children & Young People

Children and young people have different needs, present illness in a different way and require different treatment from adults. They are also subject to different legislative frameworks in terms of both health and social care and the criminal justice system. This is why we will be developing a separate document for children, to sit alongside the one for adult care and services.

The Children & Young People's strategy will aim to establish a service system that will promote the health and life chances of children throughout their contact with the youth justice system.

Women Offender's Health

In addition, it will be important to look at how health services are delivered specifically to women who come into contact with the CJS, or those who are at risk of offending within the community setting. The profile of women offenders, and the reasons they offend, are significantly different to those of men. Consequently, it will be important to improve the understanding of the health and social care needs of women who come into contact with the CJS in order to reduce their experience of health inequalities and improve their health and well-being and that of their families.

A separate programme of work is being undertaken, alongside *Improving Health, Supporting Justice*, to address the specific needs of women. This will incorporate responses to the recommendations made in Baroness Corston's *Review of Women with Particular Vulnerabilities in the Criminal Justice System*.

Strategic Plan for Reducing Re-Offending, 2008 – 11: A Consultation

This is an overarching consultation paper which provides a unique opportunity to review priorities and assess how partnerships have worked together to date. The paper consults on a Strategic Plan for reducing reoffending over the next 3 years, and will be launched to coincide with the new Public Service Agreements (PSAs) next spring. The plan will underpin the Make Communities Safer PSA and support the Social Exclusion, Justice for All and Reduce the Harm caused by Alcohol and Drugs PSAs, and will set out how Government and its partners will work together to both reduce re-offending and reduce the level of serious re-offences. *Improving Health, Supporting Justice* underscores this commitment to tackling re-offending holistically.

This strategy consultation document has been developed alongside *Improving Health, Supporting Justice – a consultation*, facilitating the shared agenda and shared priorities of improving health, reducing re-offending and crime and protecting the public.

The CJS journey.

Whilst it may seem relatively straightforward a person's journey through the Criminal Justice System (CJS) is often complicated. A simple linear progression through arrest, police detention, courts, prison and probation seldom happens. For children and young people too, a linear progression through the youth justice system does not always occur. Police investigation, new sentencing practices, lengthy waits for hearings, diversion and assessment initiatives and a stretched prison estate can make this 'journey' frustrating, confusing, anxiety provoking and physically, emotionally and socially debilitating. This is compounded by the time it takes for individuals to have a final decision about their case.

A recent report by the MoJ[3] indicated that whilst the average time taken for persistent young offenders (PYOs) to be sentenced following arrest halved overall between 1997 and 2001, it remains 57 days when sentenced in magistrates court (90% of all cases) and 199 days when sentenced in a Crown Court.

This strategy is about 'people subject to the criminal justice system' and not just offenders, because many individuals (including a particularly high proportion of women), enter the CJS but never receive a sentence, because charges are not brought or they are found not guilty or where proceedings have been terminated or where the case has been discharged. For example, the audit commission report 'Route to Justice'[4] showed that of all the defendants who were proceeded against at magistrates courts, 31% never progressed to sentencing (23% crown courts). Over 60% of women remanded in custody do not get a custodial sentence.

When we talk about 'offenders' we are referring to people who come into contact with the CJS because they have committed, or are suspected of committing a criminal offence. We need to recognise that this is an imprecise term which can be used to describe people who have come into contact with the CJS. This is a heterogeneous, ill-defined and mutable group. However, many offenders suffer excessive burden of diseases, experience poor physical and mental health and have restricted access to healthcare services.

The aim of the Youth Justice Service is to prevent offending and as a result children and young people can come into contact with the youth justice system before committing any offences, because they have been identified as being at risk of offending. The overwhelming majority of children and young people in contact with the youth justice system remain in the community throughout that contact. The average length of stay in a custodial setting for children and young people is 84 days, including time spent on remand.

[3] Statistics on Persistent Young Offenders (2007), Statistical bulletin, Issue 10/2007, Ministry of Justice

[4] Route to Justice, improving the pathway of offenders through the criminal justice system (2002), Audit Commission, London

Often individuals and their families who are subject to the CJS are from the most socially excluded groups in society including high levels of family, educational and health disadvantage and poor prospects in the labour market. (Social Exclusion Unit)[5]. Around 18,000 children a year are separated from their mothers.

This strategy is based upon recognising the individuals needs and ensuring that they have access to appropriate services to meet these needs throughout their journey through the CJS, or where appropriate, by their subsequent diversion towards health and social care services.

The principles underlying our approach to improving the health and social care of offenders are that:

- It should be recognised that the majority of offenders spend most of their lives in the community, not in custody.
- Offenders experience higher levels of health inequalities, higher burden of diseases and poorer access to health and social care services in the community than others;
- Offenders are to have the same access to healthcare, disease prevention and health promotion programmes and social care services to improve well being as non-offenders in the community and in custodial settings.
- We should educate and empower offenders in improving their health and well-being and accessing health and social care services for themselves and their family.

A survey of 1,400 women in HMP Holloway, serving their 1st sentence showed that women who go to prison are often mothers. 67%of these women had 2 dependants, which totalled over 18,000 dependants left without a mother.[6]

Rather than specifically look at areas of care (eg Mental Health, Substance Misuse, Physical Health), this consultation document looks at the diverse needs of an individual throughout their journey. It seeks to underline the multi faceted nature of care delivery and promote co-ordination of services rather than perpetuating unhelpful divisions between various aspects of care delivery.

[5] Reducing re-offending by ex-prisoners (2002) Social Exclusion Unit, London

[6] *Revolving Doors "Bad girls? Women mental health and Crime 2004"*

Section 1 – The opportunity for change

Part 1: Communities and responsibilities

Vision

To improve the quality of life through the delivery of Health and Social care which meets the needs of those in contact and potentially in contact with the CJS. This will be achieved by the provision of accessible, appropriate, creative, needs based services which offer support, choice and empowerment.

What it's like now.

The purpose of this section is to illustrate the issues surrounding offenders in the community and the positive contribution that existing health and social care organisations can make to this often socially excluded group. Underlying this, is the premise that offenders form part of the wider community and as such have the same entitlement.

The key principles in the strategic plans for criminal justice are reducing crime, protecting the public, supporting the development of safer communities and reducing re-offending. The key principle for the youth justice system is to prevent offending. The recent publication of the Home Office Crime Strategy, titled 'Cutting Crime: A New Partnership 2008-11' outlines the integral role that reducing re-offending plays in meeting wider crime reduction objectives. It also highlights that the challenge is to transform offenders into law-abiding citizens. Health and social care agencies have a significant part to play in achieving these aims by improving the understanding of the health and social care needs of this population, to reducing their experience of health inequalities, and to improve their health and well-being.

There are gaps in the identification of and support at the point of arrest for offenders whose mental health needs are manageable in primary care but whose offence is appropriately dealt with by an out-of-court disposal.

Women in contact with the CJS suffer an excessive burden of disease, experience poor health and have restricted access to healthcare and social services whilst possibly simultaneously being single parents, possibly carers for older people and/or someone with a disability. The risk of suicide in prison is much higher for women and self harm is a huge problem and 56% of all recorded incidents were in women's prisons.

Children and young people in contact with the youth justice system have high levels of need across health and social care. One third of young offenders have a mental health need. Around half have problems with peer and family relationships and a third have significant problems with education or work. Two thirds of young offenders come from backgrounds where family structure has broken down and one third have been looked after by the local authority at some point. Three quarters of

young offenders have a history of temporary or permanent school exclusion and poor attendance levels are also common.

Other organisations (e.g. probation service and local authorities) have already a history of multi-agency working and so engaged with the process more comfortably.[7]

There is a reported high prevalence of offending amongst people with mental health problems (e.g. Brekke[8] in 2001 reported that annual rates of police contact was found to be more than twice that of the general population). However, there is evidence that adults with mental health problems are less likely to be involved with serious crime such as violence, assault or 'felony offences'. 80% of women have diagnosable mental health problems the" ONS survey of psychiatric morbidity among prisons in England and Wales" reported that 40% of women prisoners admitted to having received help for mental health problems in the last year (double that for men).

Possible risk factors that might explain the relationship between offending and mental illness include instability of housing and alcohol and substance misuse.

There is a high correlation between alcohol consumption and crime, particularly domestic violence and other forms of violent crime among a specific group of offenders. There is a currently a dearth of alcohol treatment capacity for offenders and non-offenders alike.

Substance dependence is a stubborn and confounding condition. Treatment for substance misusers can be complex and demanding on clients' time and other resources. Patients and staff alike sometimes lack a thorough understanding of the nature of both dependence and treatment. Around 70% of women coming into custody require clinical detoxification compared to 50% of men, and they also have more complex poly substance misuse.

A high proportion of both boys and girls in contact with the youth justice system have a history of high levels of smoking, harmful drinking and illegal drug misuse. Recent studies indicate that alcohol misuse is considered to be a bigger problem than misuse of Class A drugs.

The prevalence and associated needs of offenders with learning difficulties and learning disabilities also needs to be considered. The Prison Reform Trust (PRT) are currently leading a UK wide programme entitled "No One Knows" which focuses on the experiences of people with learning difficulties and learning disabilities who come into contact with the Criminal Justice System. Recent PRT research explores the occurrence of learning disabilities (as defined in the Valuing People White Paper*) and learning difficulties which include a wider range of impairments such as dyslexia and autistic spectrum disorders within the offender populations. A quarter of children and young people in contact with the youth justice system have learning disabilities.

[7] Improving the health of offenders in the community (2005), OHCS, Internal DH report

[8] Brekke J., (2001). Risks for Individuals With Schizophrenia Who Are Living in the Community. Psychiatric Services, 52 (10).

* Department of Health 2001

Offenders fall into three main groups; those with learning disabilities; the wider group who have learning difficulties and the largest group who have mild/borderline learning disabilities. Research by the PRT[9] shows that high numbers of the offender population (some 20-30%) have some learning difficulties or learning disabilities that will interfere with their ability to cope with the criminal justice system.

Addressing the needs of such offenders presents difficulties for the staff who work with them. The lack of specialist staff training and their unfamiliarity in dealing with the difficulties of this group make them challenging to engage with.

There are high levels of speech, language and communication diffculties among children and young people in contact with the youth justice system.

Demographic changes in the general population and sentencing policy are set to bring about significant changes to the age profile of offender population,. For example, prison population trends for England & Wales (1996-2007) (1996-2007) reveal that numbers of men aged over 60 and women aged over 50 have trebled over the past decade, compared to a one and half times increase among the 18 to 59 age group. This increase necessitates more effective integrated planning of health, social care and criminal justice services to meet this need.

How we would like it to be

The commissioning and delivery of health and social care services must take into account the needs of individuals and their families who are, have been or may be subject to the criminal justice system. Health and social care agencies at a local level are actively involved in developing and implementing reducing re-offending strategies and initiatives to develop safer and sustainable communities. These recognise the benefit to tackling social exclusion and the health inequalities associated with social exclusion. All agencies have a shared vision and approach to ensure that there is an improvement in the health, wellbeing and opportunities for offenders and their families. There is an increased awareness of the offender population in mainstream public health arenas.

The wider community benefits from agencies addressing the health and social care needs of this group in co-ordination with the criminogenic behaviour, by reducing re-offending through reducing alcohol misuse, reducing levels of drug misuse and addressing acute mental health difficulties appropriately. All public facing CJS personnel are equipped with the skills, advice and support from mental health and social services, and access to referral pathways to allow for appropriate access to health, childrens services and social care services for people in need.

The range of services provided will be appropriate, supported by best available evidence and ensure an equivalence of standards of care across the country. Primary

[9] Talbot J (2007) No One Knows, Identifying and supporting prisoners with learning difficulties and learning disabilities; the views of prison staff, Prison Reform Trust, London

care is the foundation of these services, delivered by a range of providers, and incorporating enhanced service and specialist clinician models. Community based women's centres are proven to be effective when delivered by a multi disciplinary integrated team which support the health and social care needs for the women at risk. 'One stop shop' provision, easy to access in terms of opening times and location are proven to be effective in delivering services to hard to engage young people. Children's centres and extended schools will increasingly provide opportunities for children and families to access services likely to reduce the risk of future offending.

What needs to be done

Partnership

We will work with relevant organisations (HPA, National Aids Trust, British Liver Trust etc.) to provide targeted harm minimisation advice.

We will work with local health and social care commissioners to develop and implement health needs assessments of the offender population and determine the resource implications and cost effectiveness analyses of providing the health and social care required.

We will promote the extension of projects based upon the priorities set out in Choosing Health[10] across the whole CJS pathway.

We will identify how best to support local health and social care communities in their efforts to improve the health and well-being of those in contact with the criminal justice system. This will include improving their knowledge of how to access the health services they need and improving their physical health through nutrition and exercise.

We will work with our health, social care, childrens services and CJS colleagues to develop approaches to improve co-working between mental health, primary care and substance misuse treatment services across all criminal justice domains, to meet the needs of offenders with dual diagnoses.

Practice

We will explore how we can extend the current good practice in prisons relating to health promotion and harm minimisation for blood borne diseases, occurring in prisons to those in the wider community.

We will support Hepatitis C improved testing, treatment, assessment and continuity of care for Hepatitis C.

We will support approaches which ensure the continuity of care for the treatment of TB and contact tracing across the CJS.

We will examine how opportunities for service development and patient engagement can be optimised at the Health and Social care and CJS interface.

Working with Primary Care colleagues we will explore the possibility of getting all individuals in contact with the CJS registered with a GP.

[10] Department of Health, 2004, ISBN 174559

We will work with drug treatment commissioners to ensure that services are consistent with the National Institute for health and Clinical Excellence (NICE) methadone and buprenorphine technology appraisal, guidelines on psychosocial drug treatment and the emerging Government drug strategy.

We will explore how services can increase the availability of alcohol dependence screening, assessment and treatment. There is provision within the law for a court to refer an offender for alcohol treatment, and this opportunity should be optimised to make interventions with a good basis of evidence (such as brief interventions, couples work and peer-led support work) readily available.

We will explore how all health and social care services delivered across the CJS can become gender specific.

We will support the development of improved and easy to use physical and mental health screening tools for use across the criminal justice system, including for screening offenders for learning difficulties and learning disabilities, and for screening young people in contact with the youth justice system.

We will support the development of improved tools for screening young people in contact with the youth justice system for physical and mental health needs.

We will support the better integration of the different assessment frameworks for identifying and responding to social care needs in use across youth justice and children's services (for example CAF, ONSET, ASSET and ICS).

We will explore how to strengthen and improve the role of the health worker in Youth Offending Teams. We will support PCTs in ensuring that appropriate health professionals are involved with Youth Offending Teams at a strategic level.

Linked to the Bercow Review of the speech, language and communication needs of children and young people and current service provision, we will support the development of improved needs assessment and commissioning of delivery of speech, language and communication services for children and young people in contact with the youth justice system.

We will review how health and social care services for older adults may be enhanced to address the needs of older offenders.

Guidance and Research

We will extend the remit of prison health research to include other aspects of the criminal justice system.

We will support a broadening of the remit of current research, analysis and prevention work on deaths in custody, Prison and Probation Ombudsman reports and self inflicted deaths to the full criminal justice system.

We will support approaches which develop consensus guidance on developing GMS for offenders and other socially excluded groups.

Policy

We will work with policy makers and implementers to deliver women centred holistic care across the whole of the CJS.

We will examine how we can enhance services and policy supporting the needs of offenders with learning difficulties and learning disabilities, with a particular focus around partnerships, commissioning, diversion, training and awareness.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy or the Childrens and young people's strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

To what extent should specialist dual diagnosis services be commissioned for offenders? What would their role involve?

What should the balance of resource be between service provision for the treatment of alcohol and illicit drug use?

How could we effectively measure our level of success?

Consultation questions (Continued)

To what extent should gender specific services be delivered?

What can be done to ensure increased diversion from the CJS for those with learning disabilities?

What particular areas of training and practice need to be addressed in relation to people with learning disabilities?

Are there particular equalities issues (gender, ethnicity) that are particularly relevant for people with learning disabilities?

What support is necessary to deliver integrated services and better joint working across the CJS?

What support is necessary to further develop and support integrated services and joint working for children in the youth justice system across health, education, social care and youth justice?

Part 2: Police, police custody and Crown Prosecution Service

Working in partnership, the police service can provide the gateway to health engagement. Many behaviours that lead people to have contact with the police are driven by both physical and mental health needs. As the initial point of contact with the CJS for most people, we will work with the police service to implement a framework encouraging their role as a first gateway to health and social care.

Vision

What it's like now

The police are the first point of contact with the criminal justice system for members of the public. There are around 1.3 million people arrested each year and many of those have chronic or acute healthcare needs. Often those with physical and mental health conditions are the least likely to access or have access to healthcare services in their daily lives. The police have to face, or deal with situations which could more effectively, from a health perspective, and more efficiently, from re-offending and from cost perspectives, be dealt with by other agencies. A significant number of the people the police deal with are not always accessing the treatment they need when they need it. The key focus of this work stream is in dealing with those coming into the CJS at this initial stage and their access to the right health and social care services at the right time. The work stream will focus on those on the pathway, from the street through to the police station, to the next agency or on release. The focus in health terms will be on substance and alcohol misuse, alongside mental health, although not excluding other health or social care needs.

The early period of contact with the criminal justice system, including police, the courts and prisons is particularly risk-laden in respect of suicide and self-harm with a high proportion of individuals presenting with key risk factors.

Improved access to healthcare and support whilst in police custody, consistent with that to be received at court and/or upon reception at approved premises or Young Offenders Institute/prison can lessen the risk of self-harm at the police station and at each follow-on place of custody, or upon release. However, there are statutory safeguards for the individual whilst in police detention particularly around detention periods. We have to take into account that people in detention at this stage are suspected of rather than convicted of offending. The investigative and evidence gathering process must remain an important consideration in determining how best effective access to health and social can be achieved.

The Crown Prosecution Service plays an important role in deciding whether or not a prosecution should proceed, in particular the role they may play in diverting an offender from prosecution.

How we would like it to be

Our aspiration is that service delivery will improve health, address health inequalities and reduce crime by maximising the opportunities provided by better integration of health, social care and the police. This will include examination of levels of responsibility for health and social care agencies in respect of

intervention and provision of care to the person detained at the police station and those that come into contact with the police, with a view to achieving the outcome that police officers and staff are able to access appropriate healthcare professionals to carry out an assessment of a detainee; to contribute to the risk assessment; and, where appropriate, that the appropriate healthcare professional can take responsibility for ensuring that suitable health-related accommodation is found for those in need. Public confidence in the treatment of detainees by the police would be raised by enabling access to delivery of equivalence of care for those who come into contact with the police and those in the wider NHS.

The systems, protocols and skills/knowledge that police and police staff and healthcare professionals use when engaging with people in the community and in police custody is of a consistently high standard and are gender and age specific.

What needs to be done

Partnership

We will explore the opportunities for closer links between health care provision within police custody suites and the wider NHS.

We will support the development of guidance on model protocols between police and health and social care services, to ensure effective referrals and improved service delivery.

We will of review overlapping police and health/socials care key performance indicators, to identify shared priorities and performance management.

We propose that the Crime and Disorder Reduction Partnership is fully involved in making the links between the police and health agendas.

We will seek to improve referrals and disposals through health and social agencies, with a particular focus upon mental health, drugs and alcohol.

We will contribute to the review of statutory provisions concerning the detaining of people in police custody.

Practice

We will support the development of practice to accord with Department of Health clinical guidelines on drug misuse and dependence, and NICE technology appraisal methadone and buprenorphine recommendations.

We will support the development of provision to manage safely individuals with a dual diagnosis of substance use and mental health problems, via an integrated approach.

We will support the standardisation of skills and knowledge for all police, police staff and CPS staff on health, mental health and risk management issues via NCPE (National Centre for Policing Excellence) guidance being developed by HO, NCPE, ACPO and other stakeholders

We will explore ways to improve out of hours services for mentally disordered offenders who are detained at police stations at weekends and during the night.

Guidance and Research

We will examine the potential for the piloting of differing models of health care provision in police custody suites.

We will examine the health and social care contribution to neighbourhood policing to support excluded groups pre-offence and post-arrest by improving integration and access to local services.

We will promote wider recognition of the very different health and social care needs for women and children and young people in contact with the police.

Where children and young people receive a reprimand or final warning from the police we will promote better integration of those young people into universal and targeted children's services to ensure the promotion of their well being.

We will explore the concept of 'places of care' to provide secure accommodation in cooperation with other agencies.

We will support a review of standards of forensic service provision in consultation with Faculty of Forensic and Legal Medicine and other professional bodies.

We will undertake an exploration of the health opportunities for those acting as a frontline contact for those with drug and alcohol problems, with a particular emphasis on roads policing.

We will develop systems to improve the learning from deaths in other custodial environments working alongside the Preventing Deaths in Custody forum of the Independent Police Complaints Commission.

We will support the development of good practice in addressing the requirements of the new Mental Health Act with particular reference to section 136.

We will promote the commissioning by the Home Office of national occupational standards for health care professionals in police custody being developed by Skills for Health.

Policy

We will consider different options for improving services, including exploring the feasibility for the transfer of responsibility for commissioning of health services from the police to the NHS.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

What are the key barriers currently being faced to deliver the framework envisaged by this strategy in police services?

How best can any competing tensions be avoided in delivering an integrated health and investigative process?

Consultation questions (Continued)

What are your views on NHS or NHS-led commissioning of police health services being carried out at (a) national level (b) regional level or (c) local level?

What do you consider the police service being the 'gateway to health' should mean in terms of what happens at the police station?

What conflicts may exist in terms of forensic examination and healthcare and how are these currently overcome?

What scope do you see for wider integration of the forensic, health and social care needs of victims within this structure set out in this strategy?

What level of responsibility do you envisage should be retained by the chief officer for ensuring delivery of any externally commissioned health or social care service?

How can we ensure that early contact with the police can be used to ensure that children and young people are accessing the health, education and social care services they need?

Healthcare is an established provision by police forces in police stations. What benefits and drawbacks do you consider that providing a dedicated social care provision would provide?

Consultation questions (Continued)

What do you consider is the role of the police service in providing access to social care at the police station?

What are the opportunities for developing positive health and social care interventions by working alongside community policing?

Part 3: Courts and Sentencing

We propose that courts are sufficiently able and informed, to make use of a range of appropriate disposals for those coming before them with specific health and social care needs. We believe that the courts can play a key role in the identification and assessment of health and social care needs and subsequent referral of individuals at an early stage in the justice process.

We believe that no person should be disadvantaged by virtue of their health and social care needs in obtaining justice.

Vision

What it's like now.

People brought before the courts can present with a range of differing health and social care needs, including mental health and substance misuse issues. These needs can often go unrecognised and therefore unmet, with the offender given a custodial sentence when a hospital order (under the mental health act) or a community order with a treatment requirement would be more appropriate.

There are gaps in the provision of integrated systems (Court diversion assessment and criminal justice liaison) for people coming before the courts who require specialised mental health treatment, whose behaviour does not represent so high a level of risk that they warrant detention in prison or secure NHS services. They are hard to reach and to engage and fall through the net.

The Code for Crown Prosecutors requires Crown Prosecutors to consider the public interest in each case where there is enough evidence to provide a realistic prospect of conviction. A prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour or it appears more appropriate in all the circumstances of the case to divert the person from prosecution.

The Code for Crown Prosecutors states that a prosecution is less likely to be needed if the defendant is elderly or is, or was at the time of the offence, suffering from significant mental or physical illness or there is a real possibility that it may be repeated. The CPS, where necessary, applies Home Office guidelines about how to deal with mentally disordered offenders. Crown Prosecutors must balance the desirability of diverting a defendant who is suffering from significant mental or physical ill health with the need to safeguard the public.

The courts lack universal access to alcohol services for people brought before them for antisocial and violent offences (including domestic violence) that may be related to alcohol problems. The great majority of work has been done by the Home Office in facilitating drug treatment for offenders in courts. There remains however a lack of universal access to drug interventions programme workers in some smaller courts.

The HM Chief Inspector Prison's thematic review of mental health[11], was critical that the need within prison will always remain greater than capacity, unless mental health and

[11] The mental health of prisoners. A thematic review of the care and support of prisoners with mental health needs (October 2007), HMIP

community services outside prison are improved and people are appropriately directed to them before - instead of after – custody. The thematic review also pointed out that NHS commissioners had a limited knowledge of court diversion schemes.

In 2004, the Government published the Alcohol Harm Reduction Strategy for England. This was a major milestone: it was the first cross-government statement on the harm caused by alcohol, which included a shared analysis of the problem and the programme of action to respond.

Offender Health has funded two pilot projects regarding court assessment which are evaluating a 'framework' Service Level Agreement developed in 2006.

The South West Health and Social care in Criminal Justice (HSCCJ) Partnership Board have since 2006 been working with Her Majesty's Courts Service (HMCS) to improve the service available to defendants appearing in court who are presenting as having mental health difficulties.

The second funded project titled 'A Framework for Promoting Local Service Level Agreements for the Provision of Psychiatric Reports to Crown and Magistrates Courts' is in early stages in London and covers the boroughs of Brent, Harrow and Hillingdon. This project is testing the 'framework' Service Level agreement.

The Office for Criminal Justice Reform (OCJR) has had a review of current knowledge on effective practice with regard to mentally disordered offenders carried out, and a 'Mental Health Effective Practice Audit Checklist' (MHEP-AC) drawn up on the basis of it. The MHEP-AC has now been piloted with nine Criminal Justice Liaison and Diversion/Assessment Schemes, which has shown that it can identify successful and sustainable models of effective practice.

The health and criminal justice departments and agencies are reviewing Home Office guidance on the prosecution of mentally disordered offenders.

Although opportunities for increased diversion from custody for children and young people through sentencing in the community have been identified more remains to be done to develop the relevant services to enable courts to make proper use of these provisions.

How we would like it to be

We will be considering options for taking forward our vision for courts and sentencing within the offender pathway as we develop our final strategy for publication.

Health and social care service provision in or through courts will be based upon assessed need and provided at an equivalent standard to that in the wider community. Individuals will receive timely and appropriate assessments of their mental, support, and physical health care needs. No defendant will be remanded in custody solely for the purpose of waiting for such an assessment. Court diversion/ assessment and liaison schemes will be available to all offenders and integrated into mainstream mental health services. Where a health or social care related problem is identified, court staff will be equipped with a range of skills to ensure that the person is dealt with in an appropriate and timely manner.

A court diversion scheme is not necessarily a diversion from prosecution, but is a scheme to improve access to treatment and health services, even where a prosecution is to continue.

A range of alternatives to custody will be available, including sufficient secure acute services and packages of non-residential support capable of meeting offenders mental health and social care needs and of protecting the public.

Courts sentencing children and young people will have be able to make use of a wide range of possible sentences in the community.

What needs to be done

Partnership

We will work with the court service to ensure there is a effective health component within community sentences and improved access to court diversion for women and children and young people.

Relevant partners will be supported to ensure that the necessary services are in place so that the wide range of sentences in the community and diversion from custody will be fully available for children and young people.

We will explore how we can work with the CPS to review Home Office guidance on the prosecution of mentally ill offenders.

We will evaluate the potential for health and substance misuse requirements being part of community sentences.

We will explore how we can work closely with Probation Trusts, through commissioning, joint commissioning and/or partnership arrangements, to ensure that offender health needs are assessed at the earliest opportunity in the CJS process.

Practice

We will review and support the introduction of comprehensive court assessment, liaison and diversion schemes, including by working with existing schemes to demonstrate the cost effectiveness of this model.

We will explore how universal access to alcohol services for people brought before the courts for antisocial and violent offences (including domestic violence) that may be related to alcohol problems, may be achieved.

We will support an evaluation of models of care for people detained in courts whilst waiting to be remanded, including pre-screening in health liaison etc.

We will evaluate the impact of mental health and drug courts.

Guidance and Research

We will seek to establish how current CJLD schemes are organised and available resources deployed to meet the immediate and longer-term care needs of people coming before the courts.

We will produce, in consultation with key partners in health and social care, Criminal Justice (in particular the CPS) guidance on court assessment and diversion. The guidance will incorporate knowledge and information about current court activity how is it managed, organised, funded and the volumes of people coming before the courts of different levels.

Information of the types of offences and whether people are coming from police cells, are reappearances from bail, direct from the community or from prison. The guidance will also review the current provision of court diversion schemes nationally and identify models of best and effective practice underpinned by research evidence where this exists. Any guidance must dovetail with the Code for Crown Prosecutors and CPS legal guidance.

We will outline a review of the impact of the sentencing powers for magistrates and judges and exploration of the likely health component of these powers and their inter-relationship with new powers under the Mental Health Act 2007.

We will support projects which will examine issues around the commissioning of court reports – the quality, length and timeliness of reports provided, and whether there is a consistency of standard.

We will produce guidance for commissioners relating to working with offender managers to ensure that community based services are available to offenders receiving these orders in order that they can comply with their resonsibilities contained within the Mental Health Act.

We will review how mainstream performance and audit tools may be used to audit the provision of health in court services.

We will consider the development of guidelines for sentences and training for sentencers in mental health, substance misuse and personality disorder to guide sentencing decisions.

We will support the evaluation of the impact of the new Mental Health bill and community treatment orders on disposals from court.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

To what extent would the provision of a specialised mental health and substance misuse court—based service be (a) desirable and (b) realisable?

What changes are needed to ensure the better functioning of youth courts?

Would the concept of women only courts be plausible?

Part 4: Prisons and rehabilitation

Vision

We will improve every measure of health and well being experience for every prisoner in a custodial setting. For all prisoners this means empowerment to fully engage with their own health and well being and will result in improvements, which are measurable against the experience in the wider community.

For all staff this means they will understand and be empowered to deliver a health focussed environment which also acknowledges the need of public protection.

For all prisons they will provide and environment and regime which supports improved services. They will work in partnership with health and social care commissioners to ensure this is fully achieved in every custodial setting.

What it's like now

Over the last eight years, Prison Health has been building the platform for change across the prison service and the NHS, with much of the effort focusing on information collection and analysis, policy development across government departments, workforce planning and development and lastly, performance management. The transfer of commissioning responsibility for prison health services from the public sector prisons to the NHS completed in April 2006 and it is fair to say that across the board there is a perception that there has been a general improvement in the quality and efficacy of health care provided to people in prison. However work is ongoing to ensure a consistency of approach and an equivalence of standard.

Ensuring continuity of care on admission, during the sentence, and on release is currently a key challenge facing healthcare staff and is crucial to implementing the offender health vision. The quality of healthcare at present is variable both in prisons, and across the criminal justice system, and there remain difficult obstacles in delivering integrated care across the care pathway when the patient is either referred to an external organisation or on release from prison.

The quality of mental health care for offenders (whether in prison or in the community) with so-called `common mental disorder' still lags behind the rest of the NHS. This means that treatment is not provided or it is patchy for many except the most severely ill. There are a number of signals that suggest women's mental health deteriorates whilst in prison, also suicidal ideation and self injury rises significantly during imprisonment.

For offenders who are sent to prison and are then found to be suffering from a severe and acute mental disorder that cannot be managed in prison, we have improved the speed and reduced delays in transfer to the NHS.

Overall investment on prison healthcare has increased from £118m in 2002/03 to nearly £200m in 2006/07. By 2005/06 nearly £20m was being invested recurrently in mental health in-reach.

Despite these developments the HMIP thematic review of mental health, whilst acknowledging the developments, remained critical of the gaps in provision and too much

unmet and sometimes unrecognised need in prison. The resulting recommendations from this report, and subsequent action plan will set out the direction for future improvements in prison healthcare.

At any point in time 700 people in prison are aged over 60. They have a wide range of health and social care needs, both while in prison and on release. Over 1,000 people aged over 60 leave prison every year. It is important that there is a good liaison between prison healthcare staff and their colleagues in health and social care organisations in the community to ensure that prisoners who are being released are assessed for and receive services which meet their continuing health and social care needs.

Prison continues to be a vector for the spreading of dangerous blood-borne viruses, particularly hepatitis c, but also hepatitis B and HIV. This is directly linked to opiate misuse, but also occurs through steroid misuse and unsanitary tattooing.

Alcohol services are largely absent in prison. There is evidence that some interventions can have a beneficial effect on levels of drinking, which in turn are linked to offending, often of a dangerous (eg drunk driving) or violent nature.

The prison culture for women can be particularly harsh for the most part the prisons and practices have been designed for men. Not only that but because there are so few women's prisons they are having to travel on average 62 miles from their homes making visits from family very difficult.

Young people sentenced to custody can be placed in one of the 19 Young Offender Instititutions (YOI), part of HM prison service; in one of 4 Secure Training Centres (STCs), run by private operators, or in one of the 15 Secure Children's Homes, almost all run by local authorities. There are approximately 3000 children in the secure estate at any time, and nearly 9,000 enter the estate each year. The reconviction rate is high with 70 per cent re-offending within 12 months. Although the YJB is committed to placing children and young people in secure settings within 50 miles of their home this is seldom achieved, making it hard for families to keep in regular contact with their children and harder for professionals across youth justice, health, social care and education services to plan effectively for the young person's release.

How we would like it to be

Across the prison estate, individuals in custody would receive a comparable standard of care, irrespective of where they are placed. Should individuals have been receiving care within the community prior to their imprisonment, then this care would be continued, to the same standard, in prison. Similarly upon release their care and treatment will be continued in the community. Care within the prison is to be based upon and commissioned relating to, an individuals needs and not restricted by organisational boundaries, allowing a seamless integration between primary, secondary, physical and mental health care. Care will be delivered by organisations best suited to provide that care, not based upon historical preferences or previous commissioning arrangements. Where the potential for service development and improvement exists then this will be promoted, using exiting resources more effectively (such as escorts and bedwatches). There will be greater integration between all

partners in the care and support of people in custody, with particular emphasis on new builds being on the DCMF (Design, Construct, Manage, Finance) model and the contribution each partner can make. Opportunities for individuals and their families to address and support their own health needs will be enhanced, having a much greater focus upon health promotion.

Finally, all these continuing developments are monitored and audited using an integrated performance system, locally based and controlled which is underpinned by effective information management. There is no intention to develop a separate central performance management system. This system integrates the existing performance standards of all partners without the requirements for additional elements This system promotes, shares and rewards good practice whilst providing an environment which stimulates improvement, lifts poor performers and enhances innovation.

What needs to be done

Partnership

We will promote specific disability awareness training on learning difficulties and disabilities for all staff, including within initial training for prison staff.

We will work alongside commissioners and providers of non public sector prisons to explore optimum approaches for ensuring equity of service quality and delivery.

We will include prison staff who work with children, and staff from STCs in the work of the children's workforce development programme so that children receive the care they need that is child centred and age appropriate.

Practice

We will develop and implement guidance to support commissioners to address the recommendations of the HMIP mental health thematic review.

We will support the commissioning of Mental Health services in prisons in line with the offender mental health care pathway.

We will continue to maintain the momentum of improvement and development within prisons.

We will support the implementation of the new CPA systems which integrate with community mental health service and support continuity of care, management of risk and resettlement.

We will examine the possibilities for extending the roll-out of the Integrated Drug Treatment System (IDTS) in all remaining prisons.

We will support the commissioning of Psychosocial interventions in accordance with the National Institute for health and Clinical Excellence (NICE) guidelines on psychosocial drug treatment, and with the new Government Drug Strategy. [currently out to consultation].

We will promote the screening, assessment and treatment interventions for alcohol problems.

We propose that interventions for the management of drug problems will be consistent with the new Government Drug Strategy. [currently out to consultation].

Guidance and Research

We will examine how the health services can be delivered more responsively to become gender specific in prisons.

We will promote the development of a women's specific pathway for those in custody.

We will explore the means of promoting a consistent approach with all prison, STC and SCH staff working with children. An approach that is linked into the community and school based approaches to inclusion with recognisable and proven ways of working to engage children in health promoting behaviours and educational programmes.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomesoutputs of these deliverables be effectively measured?

How should alcohol services be funded, commissioned and delivered in prisons?

How can we ensure that staff in YOIs and STCs develop a child centred approach? And how can we ensure that staff working with children across the secure estate are less isolated from each other and from professionals working with children in the youth justice system in the community.

Consultation questions (Continued)

How can we demonstrate that improving the physical and mental health of children in custody will enable them to achieve in education, develop skills and reduce the likelihood of re offending.

What needs to be done to make prison more gender specific?

How can health services, and forensic mental health services in particular, provide an effective input into the management of offenders who pose a high risk of harm to the public, through Multi Agency Public Protection Arrangements (MAPPA)?

How can PCTs ensure that they contribute adequately to a holistic, 'premium' service for PPOs?

How can private prisons be further integrated into main stream Offender Health and Social Care developments?

Part 5: Probation, Release and Resettlement

Vision

We will create a system whereby everyone released from custody will have their health and social care support needs addressed as part of a comprehensive resettlement approach. We believe that resettlement planning begins on reception into custody and is a continuous process based on the individual and their families.

It is our belief that now and in the future, these person centred services will be seamlessly provided to optimise health and social opportunity for the individual and the wider community.

What it's like now

Many offenders in the community find it difficult to access appropriate primary care and secondary services. Health needs go unmet or needs are met through inappropriate crisis attendance at hospital A&E depts.

Recently released prisoners are at a much greater risk of suicide than the general population, especially in the first few weeks after release. The risk of suicide in recently released prisoners is only slightly lower than that observed in discharged psychiatric patients. The effective resettlement/discharge of people from prison is therefore vitally important. This must be a multi-disciplinary function which addresses the full range of resettlement needs and which recognises the multiple barriers which ex-prisoners face. This is particularly important for individuals serving a sentence of less than a year, as they will have no further contact with probation services.

Achieving continuity of care and effective transition is often difficult for many offenders leaving prison and other custodial settings. Many find it difficult to register with a general practice or access mainstream primary care services.

There are theoretical, cultural, financial and historical differences between prison and health care systems that impede their capability to integrate care across boundaries for offenders and compromise efforts to reduce mental ill health-related offending.

Access to assessment and/or treatment can be difficult. In the wider NHS, there are gaps in the arrangements for risk assessment and management. Information exchange, communications and records (e.g., CPA) are patchy. There are disputes about finance and funding responsibility (e.g., for court diversion and liaison schemes); and there is insufficient activity directed towards promoting social inclusion, housing and employment for offenders.

Recent progress in the importation of FP10 prescription system this autumn/winter means that continuity of prescribed care will be improved substantially.

Each year an estimated 160 prisoners die within the first two weeks of release as a consequence of drugs overdose. It is hoped that the FP10 system will reduce this dreadful figure, but more can be done.

Offenders leaving prison with a substance misuse problem, in treatment ,are more likely to continue with their progress and consequently reduce their re-offending.

How we would like it to be

Probation Offender Managers, health and social care key workers, work together to plan, facilitate, support and monitor an individual prior to and after release from prison or during a community based sentence. Examples of good, joined up community health provision to offenders exist. They demonstrate the ability to have a positive impact on the health of this socially excluded population and improve the use of resources across NHS and criminal justice sectors but coverage across the country is patchy.

This strategy aims to promote easier and reliable access to a range of quality community services meeting the health needs of offenders, by building service capacity and tackling systems issues around information sharing and partnership development. It is important that the appropriate links are made at a regional level with Regional Offender Managers and the regional partnership boards and at a local level with Probation Trusts (boards) to ensure that the services are place to reduce re-offending and improve offenders' health inequalities. Continuity of substance misuse care will be optimised to the benefit of both the offender and the community.

What needs to be done

Partnership

We will work with NOMS to support the development of staff, services and health related standards of care in approved premises.

We propose that we work closely with probation trusts (boards) at a local level, through commissioning, joint commissioning and partnership working, to tackle the health inequalities faced by offenders and their families.

We will promote offender health and social care issues with local authorities and PCTs through the joint strategic needs assessment, the Local Strategic Partnership and Local Area Agreements, and other local partnerships such as CDRPs and Childrens trusts to ensure that offender health care services are in place.

Practice

We will support improvements in case/care management between offender managers and health and social care agencies.

We will examine how CPA and Offender Management can be effectively integrated to ensure compatibility and are supportive of improved care for offenders with severe and complex mental health needs. It is imperative that the new CPA guidance is explicit with regard to the inclusion of offenders, and support joint working across mental health services and criminal justice agencies.

We will explore increasing the rate of GP Registration for offenders with particular focus upon approved premises.

We will support initiatives to improve access to medication upon release.

We will support the piloting of a first reception healthcare screen within approved premises and probation offices e.g. to identify risk of self harm, any healthcare problems requiring immediate medical attention and facilitating sign posting to appropriate services etc.

We will support the wider provision of Resettlement and Aftercare Provision (RAP) for children and young people returning to their families and communities.

Guidance and Research

We will support the review of initiatives which improve the health and social care needs of offenders on release into either main stream primary care, mental health and substance misuse services.

We will support the development of a range of newextended service models and promotion of good practice through published guidance, conferences, learning networks.

We will explore the development of "one-stop-shops" and other pilot projects designed to improve access to services by offenders, exploring with partner organisations how they can be shared and/or rolled out across the country.

We will review the health needs of short-sentence offenders and examine ways in which health and social services can work with these individuals, their families and other agencies to improve their health status and reduce re-offending.

We will examine existing offender health initiatives, and explore how we can build on these to more effectively support staff working with high risk individuals, in particular Probation Offender Managers, Probation Service Officers and support staff. This includes Mental Health Awareness, Personality Disorder and Learning Disabilities Training for probation officers (including those based within courts), probation service officers and staff working within approved premises.

We will explore the potential role of Probation staff in probation offices and support staff working within approved premises in relation to identifying health needs and conveying health promotion messages etc.

We will explore the potential for community sentences and community orders having a greater healthcare focus and enhancing opportunities for improving health and access to services.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

How can a single system of case management be evolved for all offenders (including those not under a license on release)? How can this work span criminal justice, social and health needs?

What should our priorities be in relation to addressing the healthcare needs of those being supervised by the Probation Service?

How could resettlement services provided prior to release from prison be improved/developed in relation to health and social care?

How can this strategy support the needs of people who have served sentences of less than 12 months?

Section 2 – Making it happen

Enabling Work streams

Section 1 sets out how we think things should be; how services might look, and how this can be achieved. However, in order to get there, we need to look at how we can improve some of the basic elements, which underpin any strategic approach to change. These elements represent the infrastructure upon which changes across the sectors can be built and represent the cross-cutting areas which link the different sectors together. They can be broken down into the following areas:

- Commissioning
- Partnership working
- Provider support and development
- Information systems and management
- Service user involvement
- Workforce and training
- Governance and Performance Management
- Research and development
- Equality and Diversity
- Capital and estate management

Commissioning

Commissioning is the means by which we secure the best value for patients and taxpayers. By 'best value' we mean:

- the best possible health outcomes, including reduced health inequalities;
- the best possible healthcare; and
- within the resources made available by the taxpayer.

We have already set out in this document how many different organisations are involved in the provision of services to an individual negotiating the criminal justice system, and each of those organisations will have their own budgets, and their own ways of commissioning services. In terms of health, the NHS already has commissioning responsibility for health services for people in prisons, for offenders managed in the community, and for ex-offenders, both before and after contact with the CJS.

Offenders are also members of the wider community. They are entitled to expect the same access to care and treatment as all other members of that community. However there is considerable evidence to show that access to services is often patchy and that as a group they suffer from significant health inequality. This is the case both for offenders in custody and for those in the community whether under the supervision of the Probation Service or not. Children in contact with the youth justice service are an especially deprived and vulnerable group and as such require more than 'equaltiy' of access and provision in order to hope to attain equal life chances with their peers.

A key component of this strategy will be support for aligned commissioning to help shape and guide the relationship between NOMS and NHS commissioners. This will help coordinate decisions over the development of services and monitor performance.

What do we mean by aligned commissioning?

The joint efforts of organisations to share information about commissioning intentions, service and delivery plans, and to monitor outcomes. The aim is to ensure so far as possible that services are designed and integrated to meet the health needs of offenders, and contribute to the reduction of re-offending and the protection of the public.

A key aim will be to ensure, through aligned commissioning, that integrated health and social care services are provided for offenders in custody, in the community, and at each stage of the criminal justice process and to encourage innovative delivery approaches where needed, which improve access for a group characterised by health inequality and social exclusion. Success will be measured by both its impact on individuals in terms both of assessment of need, access to treatment, on the reduction in re-offending and public protection. In relation to children success should also be measured in terms of engagement with services and educational achievement.

Commissioning arrangements will need to build on the Department of Health *Commissioning Framework for Health and Well Being, Our Health, Our Say* and the National Offender Management Service *Commissioning Framework 2007/2008*, which together provide the policy and service delivery background. Joint working should stand on the principles established in these two publications and develop the ideas specifically in the area of the commissioning of health care for offenders.

The framework for commissioning mental health services for children in secure settings provides a clear mechanism for joint commissioning between PCTs, Local Authorities and the Youth Justice system. It provides a detailed approach to joint commissioning underpinned by principles that reflect the legislation and policy context that specifically relates to children and young people. It covers children at risk of entering, and those leaving, a secure setting and is thus relevant to commissioning for all children in contact with the youth justice system.

Consultation questions

How can we ensure the inclusion of offenders in Joint Strategic needs assessments that will be used to underpin commissioning?

How can we ensure that services are commissioned and delivered with due regard to the challenges in implementing equality and providing cultural sensitivity?

How can we best support the development of the aligned commissioning process?

How can we support local authorities and PCTs in the implementation of the framework for commissioning mental health services for children in secure settings?

Partnership Working

National partnerships

A National Partnership Agreement between the Department of Health and the Home Office was developed to oversee the transfer of prison health services from the prison service to the NHS. This high-level agreement set out the framework for the transfer, and the respective roles and responsibilities of each of the parties involved.

It will be equally important to ensure that partnership working is effective at all levels to support the improvement of health services throughout the CJS. Starting from the top, the Home Office, the Department of Health, the Department for Children Schools and Families, the Youth Justice Board and the Ministry of Justice are working together to agree how they can best work in partnership. This agreement would provide a platform for improving the way the three departments work together to deliver government priorities. All three departments are committed to:

- Improving the understanding of each others aims and objectives and the work being undertaken to deliver them
- Identifying opportunities for joint working on shared priorities
- Providing early warnings of areas in which we need to work closer to resolve issues
- Engaging openly and responsively with one another

Any national agreement should develop and maintain policies in keeping with good practice relating to healthcare in criminal justice agencies and the well being of offenders, that offer the best value for money and are in line with NHS and social care policy.

Local Partnerships

In order to effect the changes to prison health services it was important to continue to build strong partnership arrangements on a local level between prisons and their PCTs. The key mechanism for achieving this was, and continues to be, by way of prison/PCT partnership boards. The boards oversee the modernisation of health services within the prison and in most areas continue to act as the formal mechanism for conducting prison health business. In a survey of prison/PCT partnerships undertaken in 2006, partnerships typically expressed confidence in the extent to which prisoners requiring healthcare have benefited from the prison health partnership, with 77% (59/77) giving a positive rating.[12]

In looking more widely to offender health services we will need to examine whether similar support arrangements can be developed to support partnership working. We recognise that in many local areas, these partnerships are already developing, and there are already mechanisms in place to bring together the key partners to look at this agenda. We must therefore take into account the good work that has already taken place, share the good practice, and build on that. We must also look at where we can build on existing local arrangements.

[12] Prison Health Partnership Survey 2006, HMSC University of Birmingham

Crime and Disorder Reduction Partnerships (CDRPs) already work closely with many local agencies and voluntary groups to achieve a community-based multi-agency approach to crime reduction. CDRPs could consider developing these existing partnerships or building new partnerships to tackle the social exclusion faced by offenders and reduce re-offending.

In addition, Local Criminal Justice Boards (LCJBs) also have an important role in making a significant reduction both in re-offending rates and in reducing the level of serious re-offences. The aim of any future arrangements must be to draw together the key stakeholders, and be able to effectively plan, deliver, manage and monitor a seamless healthcare service for offenders which integrates with existing NHS provision and future NHS regional and national planning arrangements. For example we must explore how we work with probation trusts (boards), through the commissioning and joint commissioning of services and robust partnership arrangements, to provide effective offender health services.

While children's trust boards promote the needs of vulnerable children in their locality many will not have a specific focus on children in the youth justice system and particularly not those in custody. The current safer communities and children and young people blocks of the LAA has tended to keep the two areas linked but separate. The next round of LAAs will see the removal of these blocks, which should allow Children's Trusts to focus better on children in the youth justice system.

Consultation questions

How can we achieve better commissioning and aligned commisioning through a plurality of providers?

How can we support Children's trusts to prioritise the needs of children in the youth justice system, reflecting the health needs of children and the links between poor physical and emotional health and rates of offending.

How can this prioritisation then be extended to the children who are in secure settings outside the geographical area from which they live, emphasising the need for support services to be available prior to custody, during custody and on release, to promote the physical and emotional health needs of all of these children and young people in order to reduce the risk of their re offending and to enhance their potential to achieve their five Every Child Matters outcomes?

What is the role of managed clinical networks in advising commissioners and harmonising the agendas of the plurality of providers?

Provider Development and Support

Diversity in the provision of public services is seen as a crucial element of reform and the introduction of 'contestability', widening the market to create more suppliers, as a key component of achieving this. For children and young people the primary focus should be on supporting the capacity and capability of mainstream children's services to work with young offenders and their families.

Third Sector Organisations (TSOs) offer considerable potential to deliver efficiencies, flexibility and innovation in health and social

care services for offenders across the care pathway. Alongside this consultation, the government is also publishing the NOMS Third Sector Strategy and the Reducing Re-offending Strategic Plan consultation. These documents, whilst distinct, support one another and underscore the government's commitment to tackling re-offending holistically.

The vision for the future is that commissioners across a range of statutory bodies (including: PCTs, Police Authorities, the Court Service, NOMS through Regional Offender Managers and probation trusts (boards), Local Government, and other government departments) will actively develop the market and increase the plurality of providers across health and social care services for offenders. There will be strong relationships between the third sector health and care providers, working across reducing reoffending pathways and contributing to a more holistic package of support. For children the work of TSOs with schools, youth services, CAMHS, substance misuse services and children's social care is also important.

Third Sector Organisations have specific strengths to bring to this agenda. They already work with, and have strong links to, the "hard to reach" populations, support user empowerment and self-help models and are often the first port of call for individuals, as many are community based and more trusted than the public sector.

The *Partnerships in Public Services Action Plan* was published by the Government in December 2006 and aims to remove barriers to third sector organisations who want to become involved in delivering and designing public services. The plan brings together opportunities for the third sector to play an enhanced role in public services.

The complexities of commissioning services for offenders, compounded by the inherent operational issues that exist for managing this population, suggest that a co-ordinated and strategic approach should be taken to nurturing and developing Social Enterprise and the Third Sector within the offender health and social care sector.

In addition, there are a number of broad issues relating to Social Enterprises and the Third Sector that have the potential to impact upon the sector's entry in service provision for offenders, for example:

- Corporate/Clinical governance
- Regulator requirements
- Staffing, Pensions, TUPE
- Litigation and risk sharing
- Financial risk
- Commissioning intentions
- Market development

There are numerous TSOs which are already working alongside Prisons, Probation Services and Youth Offending Teams to deliver services to offenders as part of resettlement plans. They are seen as crucial in terms of ensuring continuity for the offender from custody to community, as they can provide a level of expertise and support unlikely to be met by statutory organisations bodies such as the Probation or Prison Service on their own

(Senior 2003 p11). There are estimated to be over 900 voluntary organisations responsible for more than 2000 projects that provide services to offenders with over 600 of these working with offenders in the community. Information from the 'Working with Prisoners Directory' identify that many of these are involved in health and/or social care services for offenders.

Consultation questions

How can the role of Third Sector Organisations be enhanced to support the aspirations of this strategy?

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

Information Systems and Management

Improving the continuity of care along the offender pathway is key to the success of any health intervention and improving the overall health of the individual. Earlier in this section we addressed the issue of improved partnership working, and how this contributes to continuity of care improvement. In addition, we will also need to look at the importance of effective information systems and management as the other component of successful continuity.

Information on individuals in the CJS may be collected for a number of different purposes; managing the offender while in contact with the criminal justice system; identifying and managing risk; and, providing health care. It should be recognised that these are not always mutually compatible nor transferable. All three may be applicable at a single point of the criminal justice system - and tensions may result when information gathered for one purpose is requested for another as the purpose for collection will govern how it can be used.[13]

Delivering effective systems to support the management of service user information across health, social care and criminal justice is a complex undertaking. Offender health already has a specific work stream co-ordinating this activity, but additional focus is necessary when considering the wider CJS journey. Specifics include, information sharing, standards development, records management (including person held records), risk management and multi-agency training.

For children information systems need to be able to link into developments such as Contactpoint, Integrated Children's Services, and CAF.

[13] Report on Data Flows and Information Sharing, NACRO

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomesoutputs of these deliverables be effectively measured?

How can we ensure congruence between the different information systems that relate to children?

Service user involvement

For health and social care to fulfil its potential, service users should take a substantial role in shaping the care system's development, and patients and service users should be kept well informed of clinical processes and decisions. Seeking the views of others and having mutual regard for them will help to ensure that services are designed and adapted to respond better to people's needs. It also ensures the development of an evidence base for important decisions.

The majority of health services received by individuals negotiating the CJS are NHS services. Section 11 of the Health and Social Care Act 2001 (now S242 of the consolidated NHS Act 2006) places a duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes. It will be crucial to ensure that a stakeholder and user voice is integral to the development, implementation and delivery of *Improving Health, Supporting Justice*.

In addition, as NHS patients, it will be important to ensure that individuals are able to access, and are aware of their existing right to access, the same Patient and Public Involvement mechanisms as the general public; the NHS complaints process, Independent Complaints Advocacy Services (ICAS), Patient Advice and Liaison Services (PALS) and Local involvement networks (LINks). It is our intention that the views of patients, carers and others are sought and taken into account in the design and planning of the strategy and subsequently at all stages of the offender pathway in relation to health and social care.

Consulting with children, young people and their families is now a well established undertaking in all children's trusts, in the development and evaluation of services. Such consultation mechanisms are not as well established in YOIs for children and young people, to ascertain their views about how their needs have been met, while in custody, whereas systems are in place for such consultation in Secure Children's Homes and some STCs.

Consultation questions

Are the correct priorities identified in this section, if not, can you suggest alternatives?

Do you have any examples of good practice that can be cited in the main strategy?

Are there any significant areas which have been missed in this section?

How could the outcomes/outputs of these deliverables be effectively measured?

How can best practice in relation to consulting with children and young people in custody and their families best be shared across the secure estate?

Workforce and Training

Improving Health, Supporting Justice covers all the criminal justice agencies, as well as the NHS, all of whom will have different workforce make-up and structures. The workforce element of the strategy will need to support good practice across a variety of workplaces and will aim to support the existence of the right size, skill-mix and diversity in each of the relevant services.

We will need to look at maximising the potential of the current workforce, as well as encouraging work across the traditional sector boundaries. We can do this by identifying and supporting appropriate training and lifelong learning opportunities, and ensuring that the workforce is properly equipped to deliver a quality service.

It will be crucial to identify the impact of any proposed policy changes on the offender health workforce. In addition, many people working in the criminal justice agencies regularly deal with individuals with significant health problems, and it will be important to take this opportunity to ensure that they are appropriately trained and supported to do so. It may also be appropriate to look at providing access to specialist gender specific training.

We will work with Health, Social Care and CJS agencies to ensure that all staff working with children and young people in contact with the youth justice system are appropriately trained in child development, including emotional and behavioural development.

Consultation questions

What are the various sources of funding that can support training and supervision for the those working with children in the youth justice system?

What are the career pathways that can support staff recruitment and retention?

What are the current problems in ensuring consistency of training for staff working across the different settings in the secure estate?

Governance and Performance Management

As with commissioning, each CJS agency, and the NHS and social care bodies, will have different systems for managing their performance. Added to the difficulties in identifying offenders and ex-offenders in the population that access mainstream NHS services in the community, this makes measurement of services, and any improvement of services to this population extremely problematic. In addition, there are a number of other issues

that need to be taken into account when looking at integrating performance management information across the CJS.

There are a number of barriers and issues that will need to be addressed in order to ensure effective performance management across the criminal justice system.

Mainstream performance management processes in place do not currently identify offenders as a distinct group and there will need to be a balance between measuring services for offenders as a distinct group, and ensuring that they are mainstreamed as part of the general public.

We have yet to establish relationships with public sector regulators outside of those in relation to prison health services.

The contracted-out prison estate is not currently accountable to any public sector regulator and legislation would be needed to address this gap.

The overall aim of this strategy should be to ensure that performance, governance and accountabilities oversight systems are in place and integrated to improve health services for offenders at all points across the offender pathway.

Consultation questions

How can the offender population be identified within mainstream performance management systems?

How can we identify and bring together the key indicators in relation to health, specific to offenders, throughout the offender pathway in order to measure the whole experience of the offender throughout the pathway?

How can we measure the effectiveness and impact of *Improving Health, Supporting Justice*

How can we ensure that appropriate governance processes are in place and continue to be fit for purpose against change, both internal and external, to prisons?

How can we amalgamate prison-specific health services performance management processes into mainstream NHS system, without losing focus on prisoners as part of the overall NHS population?

How can we maintain the profile of prisoners, offenders and prison health services within the new regulator?

How can we ensure that the HMPS Gender Specific Standards are accounted for?

How can we ensure that governance and performance management applies across a child or young persons pathway through the youth justice service – including the crucial post release phase, where they will need ongoing, individualised care, often from mainstream services?

Research and Development

All offender healthcare services should be designed and developed on evidence based best practice principles. In addition, Offender Healthcare Research & Development activity needs to be co-ordinated and funding opportunities maximised.

Access to funding for research priorities in general is limited, and undertaking cross sector research requires ethics approval across several organisations. Whilst approval maybe attained from one agency, it maybe declined elsewhere. The lengthy ethics procedures can detract from commencing Research activity, and securing both initial funding and employment of research staff.

This can be particularly problematic when cross sector and criminal justice agencies have competing demands in relation to policy and also competing priorities for R&D activity.

To support the transfer of prison health services to the NHS, a Prison Health research network was set up. This acted as a focal point for identifying research priorities and addressing gaps in prison health research and evidence. It may be useful to explore how this model could be used to cover the broader criminal justice agenda and support the following:

Development of a knowledge base.

Identification of current research activity addressing the needs of offender health throughout the criminal justice sector.

Identification of inter-agency offender health research opportunities.

Planning and co-ordination of offender health R&D activity.

It is important that research on the effectiveness of interventions with the child population and on outcomes over children's transition to adult care is included in the agenda.

It is also important, with so many stakeholders, that proper attention is given to discussion and dissemination of the findings from research and that there is a mechanism for feedback into local commissioning and service development.

Equality and Diversity

Before they come into contact with the criminal justice system, most prisoners have a history of social exclusion, including high levels of family, educational and health disadvantage, and poor prospects in the labour market. People from black and minority ethnic backgrounds are over-represented in almost all the dimensions of social exclusion described above. It is no coincidence that people from some black and minority ethnic backgrounds are over-represented in the prison population.[14]

All offenders, irrespective of race, gender, disability, age, ethnicity, religion and sexuality should be able to secure the same access to healthcare services as the rest of the offending population. Equality and diversity needs to be a key theme that will run throughout the offender strategy.

[14] Reducing Reoffending by ex-prisoners; Social Exclusion Unit Report, July 2002

For children we need to ensure the capability of services to meet individualised needs: for younger children as well as adolescents, for girls, for young people from black and minority ethnic groups, for children with learning difficulties and for disabled children. Co-morbidity is a key feature of these young people's health and social care needs.

It will therefore be vital to establish an equality impact assessment process for all Offender Health functions and policies to enable compliance with the statutory obligations as set out in the Race Relations (Amendment) Act 2000 and other equality legislation.

In addition, all workstreams and policies must be developed to meet the differential physical and mental healthcare needs of different groups of minority ethnic prisoners, as in many cases minority ethnic communities suffer disproportionately from certain health conditions.

Not only must we ensure that the service user voice is heard (see Service User Involvement section) but that the views of offenders from BME communities are sought and taken into account in the design, planning, delivery and improving of health care services at all stages of the offender pathway.

The difficulty arises due to individual organisations within the criminal justice system producing their own race equality and diversity schemes in isolation and failing to link these up in relation to the wider offender pathway.

Consultation questions

How can we ensure that the professional development of staff reflects the needs of their client group?

How can we ensure that PCTs include prison healthcare as part of their wider impact assessment programme?

How can we effectively monitor the ethnicity of the offender population in the absence of joined up IT systems?

How can we ensure that the gender equality duty is being delivered?

Capital and Estate Management

Current situation

Offender Health Estates is responsible for ensuring prisons have adequate facilities to maintain and develop delivery of healthcare services appropriate to the role of the prison.

Currently our work does not venture into the police, court or probation settings but it does cross cut all four themes of the key areas for Service Improvement i.e.

- Standards of Care
- System reform
- Criminal Justice System
- Development and Delivery.

The Ministry of Justice is building an additional 8,000 places by 2012 with 2,000 places being available this year. We will work with the Ministry of Justice to ensure that healthcare facilities in establishments are modernised as

far as is possible and used more effectively to deliver healthcare and drug treatment programmes to reduce re-offending.

Capital expenditure is often required to facilitate the improvements needed. Significant increases in the capacity of a prison often requires some expenditure either for capital outlay and set up costs or uplift in recurrent funding or both.

The Offender Health Estates team work closely with Offender Health Finance and NOMS to agree financial allocations aligned to the Capacity Programme. In light of the Corston recommendations the women's estate is being reviewed and we will respond to any changes accordingly.

We support the development policy and standards to ensure healthcare environments are appropriate to deliver safe and effective clinical services regardless of location. This ensures safe working practices are supported, protect patient safety and staff and reduce the risk of litigation. It also leads to improved efficiency and support the local workforce strategy.

We wish to strengthen relationships with commissioners and partnerships as part of the planning to accommodate an increased population, change of role of prison or upgrade of facilities. We also aim to support where possible, models of care that consider service redesign and that make best use of resources in line with transfer of escorts and bedwatch funding.

Consultation questions

Service users – How will Partnerships inform the Offender Health team on service user views of the prison healthcare facilities and environment?

What is the best system to forward concerns documented by PCT/Prison Governance groups? (include information on accessibility, appropriate environment – confidentiality, dignity).

How can we best make use of emerging evidence about the impact of design on behaviour?

Section 3: Proposals for Development of the Strategy

As previously indicated, this consultation strategy is not costed as it is at an aspirational stage, however, a cost assessment will be carried out before any final publication of the main strategy. No commitments can, as yet, be made to new requirements. Currently the Offender Health workstream from the Department of Health is supported through a regional network, which is funded centrally. Where existing funding is involved, subject to any cost assessment, it is proposed that the strategy will consider how better use may be made of this funding to achieve outcomes by doing things better. The strategy may include a refocussing of existing regional work programmes, to make better use of resource currently allocated.

It is not yet clear what the DH regional presence will look like. DH is currently working through the future arrangements for the government's regional presence, and the Offender Health and Social care Strategy delivery programme will fall across that work. It is important that at a regional level the appropriate links are made with the Regional Offender Manager within NOMS and the regional reducing re-offending partnership boards in England and Wales. It is suggested that these regional boards should play a key role in ensuring that the planning for offender health services links with regional reducing re-offending action plans.

It is proposed that key to the delivery of this strategy would be effective partnerships between Strategic Health Authorities, Public Health Departments, Social Care organisations, Ministry of Justice and Home Office organisations at a regional level to ensure that priorities are shared, lines of accountability and audit assured and resources are managed effectively.

However, at this stage it is also important to focus nationally on the outcomes, and to allow local partners to develop approaches which are relevant to their local structures. It is suggested that a key outcome would be to achieve coherent and joined-up partnership planning involving all relevant partners including Regions reducing re-offending programme boards and Local Area Agreements.

Consultation questions

What are the most effective regional and local structures to ensure delivery of the strategy?

What role would third sector organisations play in the delivery of this strategy?

What do you think are the key resource implications in delivering this strategy?

Glossary of Terms

ASRO	Addressing Substance Related Offending
CDRP	Crime and Disorder Reduction Partnership
CJA	Criminal Justice Act
CJIT	Criminal Justice Information Technology
CJS	Criminal Justice System
CPA	Care Programme Approach
DAT	Drug Action Team
DCA	Department for Constitutional Affairs
DCSF	Department for Children, Schools and Families
DDA	Disability Discrimination Act
DfES	Department for Education and Skills
DIP	Drug Interventions Programme
DRR	Drug Rehabilitation Requirement
DTTO	Drug Treatment and Testing Order
ECP	Enhanced Community Punishment
EFQM	European Foundation for Quality Management
ELWa	Education and Learning Wales
EM	Electronic Monitoring
FM	Facilities Management
GMS	General Medical Services
GSI	Government Secure Intranet
HMCS	Her Majesty's Courts Service
HMIP	Her Majesty's Inspector of Prisons
HMPS	Her Majesty's Prison Service
HO	Home Office
HOPS	Health and Offender Partnerships
IAPS	Interim Accredited Programme Software
ICCP	Intensive Control and Change Programme
LCJB	Local Criminal Justice Board
LSC	Learning and Skills Council
MAPPA	Multi-Agency Public Protection Arrangements
MHA	Mental Health Act
MoJ	Ministry of Justice
NOMIS	National Offender Management Information System
NOMS	National Offender Management Service
NPD	National Probation Directorate
NPS	National Probation Service for England & Wales
NSMART	National Standards Monitoring and Reporting Tool
NTA	National Treatment Agency
NTORS	National Treatment Outcome Research Study
OASys	Offender Assessment System
OGRS	Offender Group Reconviction Score
OLSU	Offender Learning and Skills Unit

OLASS	Offender Learning and Skills Service
OMNI	Offender Management National Infrastructure
OSAP	Offender Substance Abuse Programme
PPO	Prolific and other Priority Offender
PSA	Public Service Agreement
PSR	Pre-Sentence Report
RCGP	Royal College of General Practitioners
RR(A)A	Race Relations (Amendment) Act
SCI	Street Crime Initiative
SGC	Sentencing Guidelines Council
VFM	Value for money

Membership of the Executive Steering Group

Richard Bradshaw	*Director of Offender Health*
Savas Hadjipavlou	*Director of Health and Offender Partnerships*
Fiona Adshead	*DG, Health Improvement, Department of Health*
Peter Edmundson	*Police Liaison Policy Unit, Home Office*
Ron de Witt	*HM Courts Service*
Jonathan Sedgwick	*Office of Criminal Justice Reform*
Roger Hill	*National Probation Service*
Susannah Nisbett	*Department of Health, Offender Health*
Mark Johnson	*Department of Health, Offender Health*
Juliet Lyon	*Prison Reform Trust*
Lord Victor Adebowale	*Turning Point*
Angela Greatley	*Sainsbury Centre for Mental Health*
Jenny Shaw	*Prison Health Research Network*
Peter Lawler	*Welsh Assembly*
Kieron Murphy	*Care Services Improvement Partnership*
Sarah Mann	*Home Office*
David Behan	*DG Social care, Department of Health*
Julie Taylor	*Director of Commissioning, NOMS*
Peter Mankin	*Chief Executive, Dorset PCT*
Sarah Payne	*Regional Offender Manager, South East Region*
Sally Averill	*Crown Prosecution Service*

We would also like to thank the following for their contribution to the work of the steering group and the strategy development:

Alan Brown	Police Liaison Policy Unit
Nick Lawrence	DH Health Improvement
Caroline Hawkins	Turning Point
Rowena Williams	Welsh Assembly
Tony Robson	ROM
Ged Bates	National Probation Service

Jane Senior	Prison Health Research Network
Claire Crawley	DH
Patricia McFarlane	Police Powers and Protection Unit
Deborah Hudspith	Police Powers and Protection Unit
Brian Roberts	Police Powers and Protection Unit
Karen McLeod	NOMS
David Crawley	Independent Advisor
Frances Flaxington	NOMS
Spencer Draper	NOMS
Ben Clark	NOMS
Bobbie Jones	Offender Management
Robert Ritchie	Office for Criminal Justice reform

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