BALANCING ACT

Addressing health inequalities among people in contact with the criminal justice system

A briefing for Directors of Public Health

Revolving Doors Agency

PCA Probation Chiefs Association leading on probation

Public Health England

Revolving Doors Agency is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in contact with the criminal justice system. Our work has three strands: policy and research, partnership and development, and service user involvement.

To find out more about our work go to:
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The Probation Chiefs Association is the independent professional organisation that represents the professional voice of senior leaders in Probation Trusts in England and Wales. It exists to promote confidence in, and increase understanding of, the vital work that probation does to support the work of courts, to ensure that offenders are supervised in the community, protecting the public and reducing re-offending.

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- Protecting the nation's health through the national health protection service, and preparing for public health emergencies
- Sharing our information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health
- Researching, collecting and analysing data to improve our understanding of health and come up with answers to public health problems
- Reporting on improvements in the public's health so everyone can understand the challenge and the next steps
- Helping local authorities and the NHS to develop the public health system and its specialist workforce.

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If you would like further information on the content of this briefing, please contact: Esther Dickie, Revolving Doors Agency: esther.dickie@revolving-doors.org.uk

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Executive summary

Health inequalities experienced by people in contact with the criminal justice system are well above the average experienced by the general population. As well as those in a custodial setting, this includes offenders serving community sentences, those who are in the community on licence and those in contact with the criminal justice system on suspicion of committing a criminal offence. Evidence illustrates that as a group, those who have or are at risk of offending frequently suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality. These underlying health issues are often exacerbated by difficulties in accessing the full range of health and social care services available in the local community.

Within the new health service commissioning landscape, Directors of Public Health, share responsibilities for and have a direct interest in addressing health inequalities among people in the community who are in contact with the criminal justice system. Tackling these issues for this vulnerable group will help Directors of Public Health to meet key national targets for public health outcomes and improve the health and wellbeing of their area. Furthermore, as poor health, including mental health, is often interlinked to offending and reoffending behaviour, Directors of Public Health can help contribute to safer communities and reducing reoffending.

Working with a wide range of partners across the health and criminal justice sectors, both locally and nationally, will be fundamental to tackling this shared agenda on health inequalities among people in contact with the criminal justice system. Directors of Public Health are well placed to play a proactive and key coordinating role.

This briefing paper suggests positive actions and approaches which Directors of Public Health could use to tackle the health inequalities of people in contact with the criminal justice system residing in their community:

- Understand the specific health needs of those in contact with the criminal justice system in the local community through using the available health data from criminal justice agencies, particularly the local probation service, in the Joint Strategic Needs Assessment process.
- Build upon existing partnership arrangements and forums with overlapping membership, to coordinate this local offender health agenda e.g. Community Safety Partnerships, Drug and Alcohol Action Teams, Integrated Offender Management ("IOM") and Safeguarding Partnerships, and working with Health and Justice Public Health Specialists within Public Health England Centres.
- Work with partners to address other common risk factors and determinants associated with poor health and offending, such as homelessness. Develop a comprehensive and joined up strategy to tackle deep rooted and interrelated problems facing local communities.
- Explore opportunities for joint commissioning with partner agencies and utilise the increased flexibility being given across a range of public service areas to tailor solutions locally. The report highlights emerging initiatives which co-locate different services under one roof, and tailor multiple services around the needs of service users, as illustrations of promising practice.

Introduction

This briefing is concerned with health inequalities among people in contact with the criminal justice system residing in community settings. It is intended to support Directors of Public Health as they assume significant new responsibilities for improving the health of their local population. These women and men are an often overlooked group who disproportionately experience poor physical and mental health and commonly engage in high risk behaviours. Department of Health Joint Strategic Needs Assessment guidance highlights offenders and ex-offenders as a group who have multiple and complex needs who will need to be considered if health improvements among the whole population are to be achieved.[1]

The return of oversight of public health to local authorities and the emphasis on addressing the wider determinants of health opens up new opportunities for Directors of Public Health to address these health inequalities. Partnership working with criminal justice stakeholders is recognised as fundamental, given the shared goals and incentives to reduce reoffending and create safer communities. Unemployment, poor housing, family breakdown and substance misuse are common determinants of both reoffending and poor health outcomes. Criminal justice partners, and in particular probation trusts, who work closely with offenders to assess their needs, have an in-depth understanding of the specific health and wellbeing challenges faced by local offender populations. Joint, innovative initiatives that adopt a holistic approach to improving the health and wellbeing of people in contact with the criminal justice system have the potential to bring about health improvements among this group as well as their families, and to deliver community-wide health and wellbeing outcomes through reduced reoffending and safer communities.

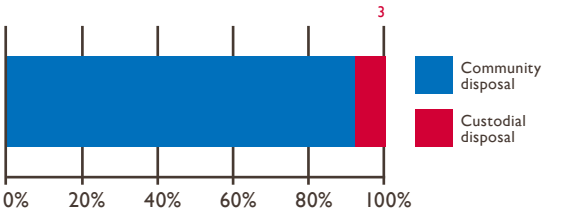
Who is responsible for the health of people in contact with the criminal justice system in the community?

Healthcare for people in contact with the criminal justice system may mistakenly be seen as falling exclusively under the remit of NHS England, who assumed responsibility for commissioning healthcare for offenders within custodial settings in April 2013. In fact, NHS England Health and Justice teams only have responsibility for commissioning services within police custody, the courts, prisons and the secure estate. The proportion of offenders living in the community far outweighs those within the custodial estate.

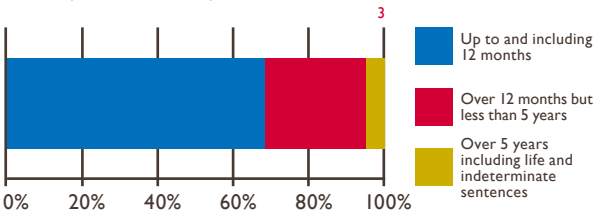
BOX 1

People in contact with the criminal justice system: inside and outside the secure estate

The number of people supervised in the community by the probation service is nearly double that of the adult prison population (in 2011-12 this was 159,042 and 83,757 respectively).[i] [2] However, this does not capture the full extent of people in contact with the criminal justice system in the community.



The probation caseload figure above excludes prisoners released back into the local community from sentences of less than 12 months, who are not currently managed by the probation service.[ii] The vast majority of custodial sentences issued by the courts are for short periods of imprisonment.



While Clinical Commissioning Groups (CCGs) have responsibility for commissioning services for people in contact with the criminal justice system as members of the wider community, Directors of Public Health have specific duties to improve the health of this group as part of their remit to reduce health inequalities, and will need to work closely with CCGs and Public Health England in understanding and addressing the health needs of this population.

Those offenders who are sentenced to periods of imprisonment should still remain a concern for Directors of Public Health. Healthcare delivered in prisons can have a significant impact on improving health and wellbeing both inside and outside the prison walls, such as the decrease in acute Hepatitis B among injecting drug users in the community, which has been attributed to prison-based vaccination programmes.[4] However, the vast majority of custodial sentences are for relatively short periods of time. Over a third of all custodial sentences issued by the courts in 2011 were for periods of less than 3 months and over half were for less than 6 months,[3] thereby offering only limited opportunity to engage with prison-based health services. A recent large-scale survey identified that just one in fifteen short-sentence prisoners accessed help from mental health services while in custody, despite estimates that one in three in this group suffer from anxiety or depression, and one in ten from psychosis.[5] The transitional period from the relatively stable environment of the prison setting back to often chaotic lifestyles in the community, is a period that has been linked to dramatically increased risks to health and death.[6, 7, 8]

There is growing awareness of the multiple and complex health and social care needs of people in contact with the criminal justice system, with recent government recognition of the need to extend support to prisoners as they return to the community to reduce the high reoffending rate among released prisoners:

> *“Offenders often lead chaotic lives: Broken homes, drug and alcohol misuse, generational worklessness, abusive relationships, childhoods spent in care, mental illness, and educational failure are all elements so very common in the backgrounds of so many of our offenders. And right now, we are failing to turn their lives around.”*
>
> ***(Secretary of State for Justice, Chris Grayling)***[9]

BOX 2

Transforming Rehabilitation proposed reforms

The government has recently announced significant reforms to the management of offenders upon release from prison. As part of the Transforming Rehabilitation reforms, the supervision and rehabilitation of all low and medium risk offenders will be contracted out to the private and voluntary sector across 21 contract package areas in England and Wales.

A new National Probation Service will retain responsibility for providing services for high risk offenders. They will continue to have responsibility for assessing the risks posed by offenders, enforcement of breach of licence or sentence conditions and providing information to the courts for sentencing purposes.

The reforms also include plans to introduce a network of 70 resettlement prisons in which male prisoners will spend the final three months of their sentence close to the area they will be released to, in order to improve ‘through the gate’ support.

Finally, the Offender Rehabilitation Bill 2013-14, introduced into the House of Lords in May 2013, includes provision to extend supervision on release to prisoners serving sentences of less than 12 months, who unlike longer sentence prisoners are not currently supervised post-release by the probation service.

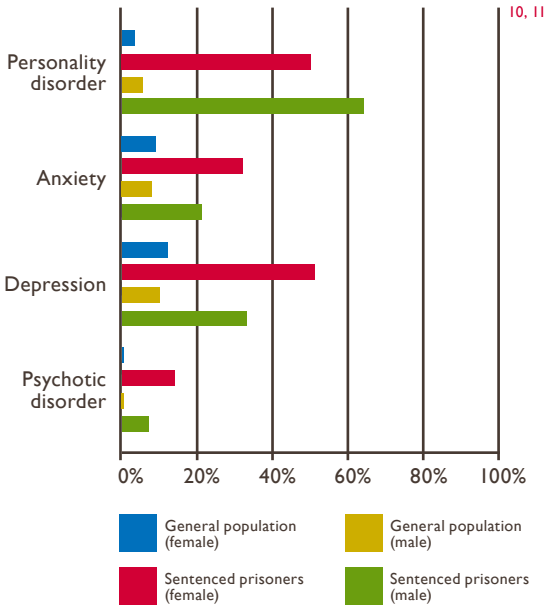
i. The number of offenders managed in the community includes those sentenced to a community order, a suspended sentence order, or who are under supervision following release from custody.

ii. Under the government’s Transforming Rehabilitation proposals supervision upon release will be extended to also include those who have served custodial sentences of less than 12 months. Further details of this reform programme are included in box 2 of this briefing.

Health inequalities among people in contact with the criminal justice system

In comparison to research examining the health of the prison population, relatively little research has been undertaken in relation to people in the community who are in contact with the criminal justice system. Research undertaken has been largely confined to county level studies, presenting some difficulties in compiling a national picture. However, these indicate that prevalence levels across a range of disorders are comparable with those identified among the prison population suggesting a similar health profile across both domains. In order to present a more robust analysis of health inequalities among people in contact with the criminal justice system, it has proved necessary to include a number of large scale studies based on the prison population. Where available, separate data on the health of women in contact with the criminal justice system has also been included, revealing even higher levels of health inequalities.

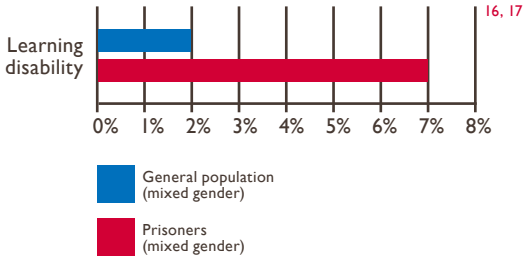
Mental health of people in contact with the criminal justice system



Key issues

- Mental health needs among those in contact with the criminal justice system are often complex, with co-morbidity the norm among this group. In a study of prisoners, **72%** of male, and **71%** of female prisoners were found to suffer from two or more mental disorders (including personality disorder, psychosis, neurosis, alcohol misuse and drug dependence). **20%** suffered from four.[10] Presence of concurrent mental health and substance misuse problems can lead to difficulties in accessing support from either service.[12] In a study of offenders on probation, **72%** of those identified as having a mental illness were also found to have a substance misuse problem.[13]
- Many people in contact with the criminal justice system have experience of interpersonal trauma, particularly women offenders. This has been linked to the onset of a range of mental health problems including post-traumatic stress disorder, depression, anxiety disorders and substance misuse.[14] **29%** of prisoners report having experienced emotional, physical or sexual abuse as a child, with the percentage much higher among women prisoners.[15] Limited availability of trauma informed mental health services can lead to poor responses to this client group.[14]

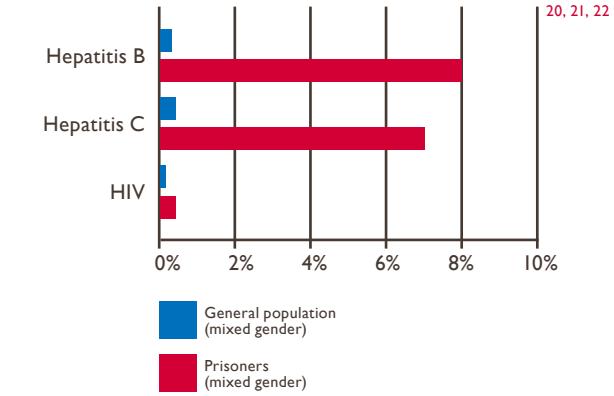
Learning disabilities and difficulties among people in contact with the criminal justice system

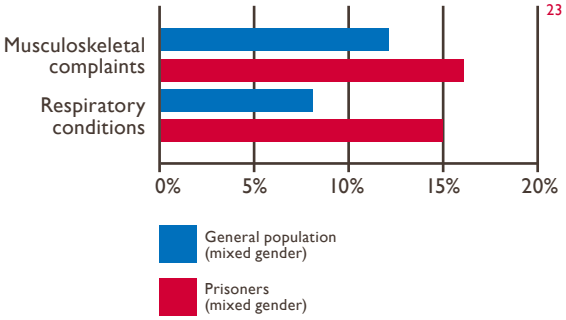


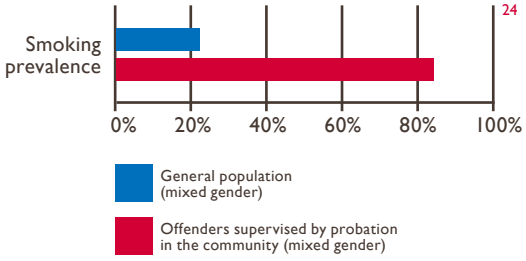
Key issues

- People with learning disability are at increased risk of a range of physical health conditions, including respiratory disease, coronary health disease, as well as some mental health conditions, including schizophrenia.[18] However, difficulties in understanding and communicating health needs, a lack of support to access services, discriminatory attitudes among health care staff and failure to make 'reasonable adjustments' can create significant barriers in progressing within mainstream healthcare services.[19]
- Up to one quarter of the prison population are understood to have difficulties in communicating and/or processing new or complex information, while not meeting the strict diagnostic criteria for a learning disability,[17] and may not be eligible for support from community learning disability services following release.

The physical health of people in contact with the criminal justice system



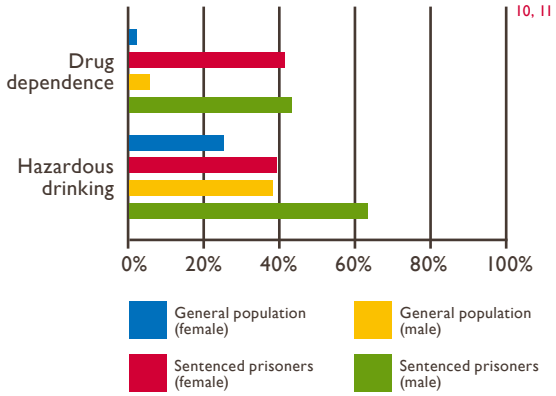




Key issues

- A survey of over 200 detainees held in police custody in 2007, identified "a very large and complex, mixed disease and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis and pulmonary embolism, hypertension, gastrointestinal disorder, hepatitis and musculo-skeletal issues, were all present with [greater than] >5% representation".[25]
- Prisoners over the age of 60 are the fastest growing age group in the prison estate across England and Wales. It is estimated that approximately 10% of the prison population are over the age of 50, and that 80% of this group have a long standing illness or disability.[26] Older prisoners are likely to experience an accelerated ageing process, with a physiological age ten years older than their contemporaries in the community.[27] This group are likely to have particular health and social care needs upon release that will need addressing, with continuity of care and support at prison release being particularly important.

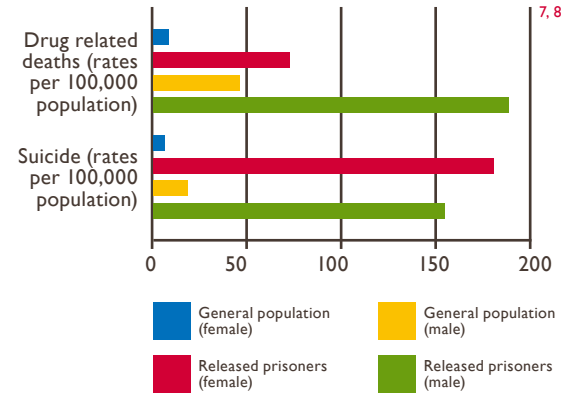
Substance misuse among people in contact with the criminal justice system

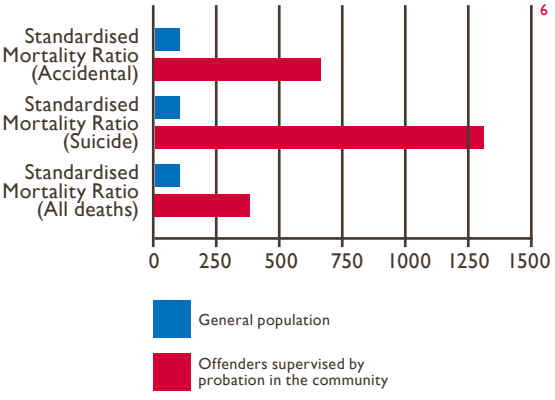


Key issues

- Alcohol misuse is often directly linked to violent offending, domestic abuse and anti-social behaviour. Alcohol treatment services in the community have historically been under-resourced, and securing specialist treatment for offenders serving community sentences with alcohol treatment requirements attached is reported to be particularly problematic in some probation areas. Currently only 3% of community orders issued include an Alcohol Treatment Requirement.[28]

Risk of premature mortality among people in contact with the criminal justice system





Key issues

- People in contact with the criminal justice system are recognised as a priority group within the current cross-government suicide prevention strategy,[29] and have proportionately more risk factors for suicide, including increased prevalence of mental illness, substance misuse and socioeconomic deprivation.[7] Suicide risk is at its highest at key transitional points in and out of the criminal justice system, with risk among recently released prisoners at its highest within the first 28 days of release.[7]
- Drug related mortality among recently released prisoners is at its highest during the first week following release[30] emphasising the importance of through the gate support following release from the structured and relatively drug free prison environment.

Considerations in addressing health inequalities

In examining how use of primary care services among socially excluded groups, including offenders and ex-offenders, can be improved, the Cabinet Office's Inclusion Health report stated: *"socially excluded clients often have a long standing mistrust of services and may not understand or engage in appropriate ways. For mainstream practitioners, it can be hard to tune into the complex needs of socially excluded groups and allocate sufficient time and tailored interventions to meet the complexity of their needs"*.[31: p13] A number of key barriers in accessing and engaging with mainstream health services have been identified among people in contact with the criminal justice system, which can act to deepen health inequalities and limit inclusion within health screening and protection programmes (see Box 3).

BOX 3

Key barriers in accessing and engaging with healthcare services among people in contact with the criminal justice system

Complex health and social care needs

High levels of co-morbidity and concurrent social problems are found among people in contact with the criminal justice system. There may be challenges identifying which service should take the lead so that they find themselves 'bounced' between services. Alternatively, where individual needs are not sufficiently severe to meet service criteria for secondary or specialised services, primary health care services may struggle to respond to their complex presentation. Practitioners may not have appropriate skills or training and may focus on immediate symptoms rather than long term recovery.

Chaotic lifestyles

Homelessness, substance misuse, involvement in prostitution, high levels of transience and otherwise 'chaotic lifestyles' can lead to difficulties in adhering with rigid appointment systems or attending in regular office hours.

Low levels of help seeking behaviour

In a study in one probation trust area, offender managers reported a low presence of health seeking behaviours among offenders supervised in the community.[24] Distrust of services, linked to previous negative experiences of contact with statutory services, such as being taken into care, was identified as a barrier in accessing healthcare services in interviews with recently released prisoners.[32]

Commissioning arrangements for residents within approved premises

'Approved Premises' house recently released offenders or bailees considered to be a risk to the public. Residents, who may well be new to the area, can experience a range of barriers in accessing both primary and secondary health services. There is only limited understanding and recognition of the distinct needs of this group in local health commissioning arrangements.[33] There are approximately 100 approved premises in England and Wales, providing accommodation to 2,000 offenders at any one time.

Stigma

Those in contact with the criminal justice system may be the bearers of multiple labels which carry or are perceived to carry stigma: 'offender', 'mentally ill', 'homeless', substance abuser', 'personality disordered'. Such labels can lead to negative attitudes from professionals and act as a barrier to access or engagement with healthcare.[34]

Transition to adulthood

The transition from children to adult health services can be complex and inconsistent with a detrimental impact on continuity of care. In some areas, support from Child and Adolescent Mental Health Services (CAMHS) may only extend to the age of 16, with adult provision not available until the age of 18. In addition, for some conditions for which CAMHS had provided support there may be only limited provision available in adult services.[35] In the case of drug services, there is a different pattern of substance misuse among young adults; interactions with heroin and crack cocaine users in adult services and the stigma attached to these services have been identified as barriers to accessing adult drug services for young adults.[36] The young adult age group make up a significant proportion of the offender population, representing 10% of the general population, but over one-third of the population sentenced to prison each year, one-third of the probation caseload and one-third of those commencing a community sentence.[37]

Poor engagement with community services among people in contact with the criminal justice system, and particularly among those who have multiple or complex needs, is recognised as leading to high usage of costly emergency services by this group.[38] In a study of individuals on the probation caseload in one trust area, 39% were found to have used Accident and Emergency services or NHS Walk-In clinics in the last 12 months. 9% had used these services three or more times in this period.[24] Poor engagement with mainstream community healthcare services can also extend to the families of people in contact with the criminal justice system. Reshaping service responses in line with the needs of socially excluded groups, such as people in contact with the criminal justice system and their families, can significantly improve health outcomes among this group and reduce use of expensive crisis services.

Why should Directors of Public Health prioritise the health of people in contact with the criminal justice system?

1. Addressing the health needs of people in contact with the criminal justice system will enable Directors of Public Health to meet key national targets to improve the health of the most vulnerable

Department of Health guidance sets out clear responsibilities on Directors of Public Health to "improve the health of the most vulnerable fastest".[39] People in contact with the criminal justice system, offenders serving community sentences, or those at risk of reoffending experience poor health outcomes across a number of key indicators within the health improvement, health protection and preventing premature mortality domains of the public health outcomes framework.

BOX 4

Relevant Public Health Outcomes Framework Indicators relating to adult population in contact with the criminal justice system

2.10 Self-harm*
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are not previously known to community treatment
2.18 Alcohol related admissions to hospital*
2.23 Self-reported wellbeing
3.4 People presenting with diagnosis at a late stage of infection
3.5 Treatment completion for Tuberculosis (TB)
4.3 Mortality rate from causes considered preventable**
4.6 Under 75 mortality rate from liver disease**
4.7 Under 75 mortality rate from respiratory diseases**
4.8 Mortality rate from infectious and parasitic diseases
4.9 Excess under 75 mortality rate in adults with serious mental illness**
4.10 Suicide rate

In addition, access to screening programmes in the community is also likely to be limited among people in contact with the criminal justice system, due to periods of imprisonment and poor engagement with mainstream primary healthcare services. This can also impact upon engagement with vaccination programmes among the children of people in contact with the criminal justice system.

* Development of indicator on-going
** Indicator shared with NHS Outcomes Framework

Priorities set by Public Health England for 2013/14 include tackling: poor mental health, including depression and anxiety; excessive alcohol consumption; and smoking.[40] All of these are areas in which elevated prevalence has been found among people in contact with the criminal justice system.

2. Working to reduce reoffending and create safer communities will have health benefits for the wider population

Safer communities, which promote increased physical and leisure activities and contribute to social cohesion, are a key wider determinant of health and wellbeing. As such, working with criminal justice partners is emphasised as an important aspect of the Director of Public Health role.[41]

Substance misuse, and particularly alcohol, is a strong risk factor in violent offending. A Department of Health report, Protecting people, Promoting health, advocates a public health approach to violent crime prevention drawing on both the economic and social costs of violence.[42]

A significant proportion of public health budgets have been provided without ring fence, to facilitate the commissioning of innovative services to improve health and wellbeing. Initiatives to address the wider determinants of health are expected to feature heavily within local commissioning plans.[39] While the relationship between health inequalities and offending is multi-faceted, targeted initiatives which seek to improve the health and wellbeing of people in contact with the criminal justice system and reduce reoffending can impact on the wider determinants of health for the local population.

BOX 5

Relevant public health outcomes framework indicators

1.11 Domestic violence*
1.12 Violent crime (including sexual violence)
1.13 Reoffending levels
1.19 Older people's perception of community safety***

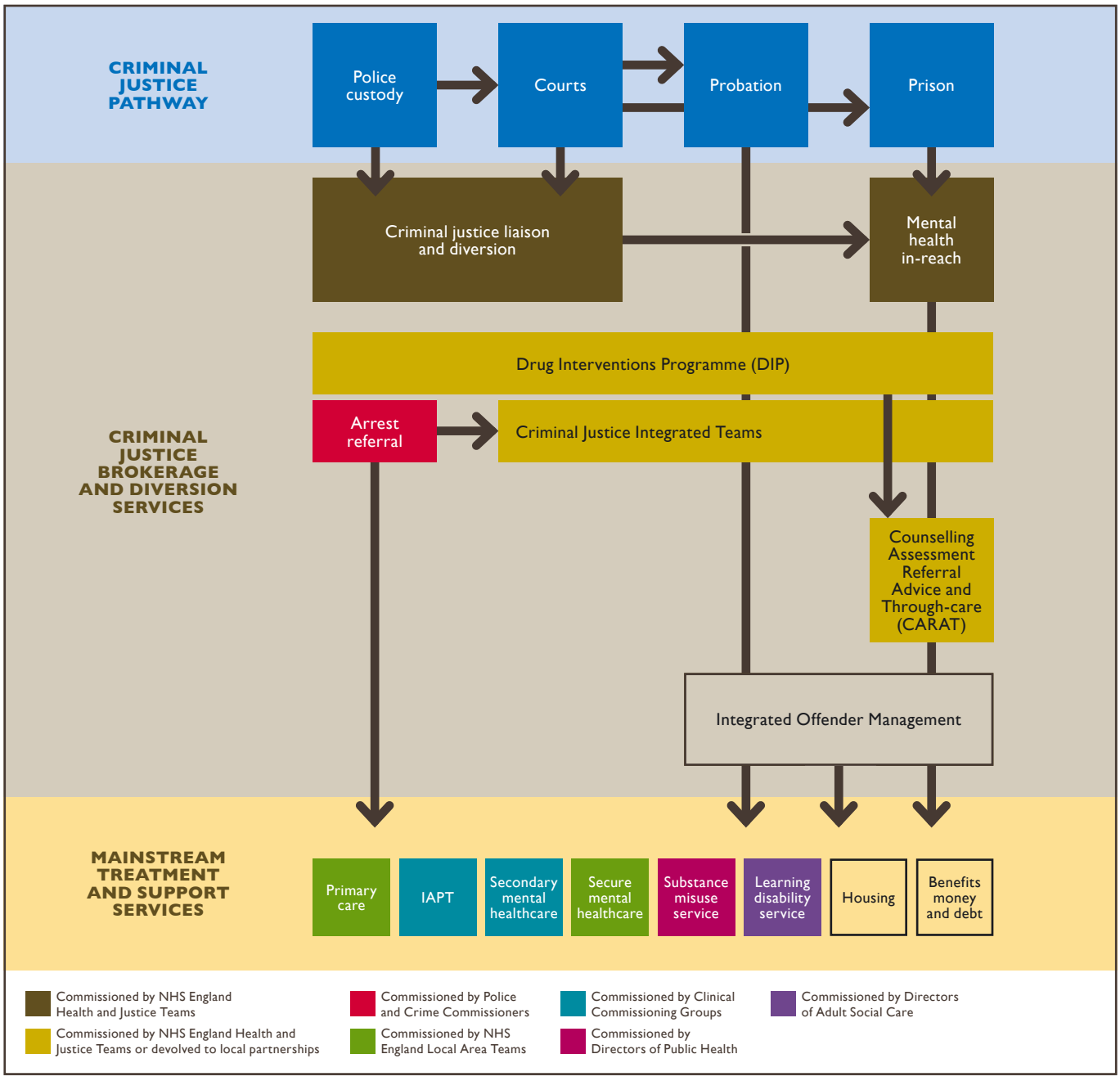
* Development of indicator on-going
*** Complementary to indicators in the Adult Social Care Outcomes Framework

3. Collaborative working with NHS England commissioners will help to improve health outcomes by strengthening pathways between custody and the community

Government guidance sets out the responsibilities for a range of commissioners to work together to improve integration of services. In relation to people in contact with the criminal justice system, the NHS Commissioning Board mandate makes clear that: *"the NHS Commissioning Board [now NHS England] and its public sector partners need to work together to help one another achieve their objectives … this includes, in particular, demonstrating progress against the Government's priorities of: … developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community".*[43]

Release from custody is a critical transition point that poses significant risks to health. In the first week following release from prison, male prisoners are 29 times more likely to die, and female prisoners 69 times more likely to die when compared with the general population.[30] Since April 2013, regional Health and Justice leads from 10 Local Area Teams of NHS England have assumed responsibility for commissioning criminal justice liaison and diversion services for people with mental health problems and learning disabilities operating in police stations and courts, as well as health services in prisons. The voluntary transfer of commissioning of general healthcare services within police custody from individual forces to NHS England is currently underway in the majority of police force areas in England, which, when completed will unify the commissioning of healthcare services across the criminal justice pathway within specialised NHS England Health and Justice teams. Close working between Directors of Public Health and these teams will be essential in delivering whole pathway approaches which reduce the health risks arising from the transition from custody to the community. As well as release from prison, well developed pathways from police custody into community services will also be important in improving health outcomes among people in contact with the criminal justice system who do not receive a custodial sentence.

The below diagram shows the key pathways out of the criminal justice system and the range of commissioners who will need to work together to deliver a cohesive and integrated response.



What can Directors of Public Health do to address health inequalities among people in contact with the criminal justice system?

Understand the specific health needs of people in contact with the criminal justice system who are living in the local community

Statutory guidance on Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) emphasises the importance of capturing the current and future health needs of the whole population, and lists offenders and ex-offenders in the community as one group who experience multiple and complex needs who Health and Wellbeing Boards will need to consider.[I]

To support this process, Public Health England together with the National Offender Management Service (NOMS) are currently developing an offender health needs assessment template to bring together data held by criminal justice agencies.

In addition, many probation trusts have already begun to collate this information to support Health and Wellbeing Boards in understanding the specific health needs of those in contact with the criminal justice system in their local area.

Qualitative evidence also has an important role to play in understanding local need. While Healthwatch will bring together the views of some community members, "engaging the views of those seldom heard and vulnerable groups"[I: p8] will also be vital in exploring health inequalities in greater depth. Peer research has emerged as a successful method in eliciting the views of hard to reach groups. Groundswell and Homeless Link have produced a homelessness and health peer activity toolkit which provides useful guidance in conducting such projects.[iii]

It is crucial that needs analysis considers the distinct needs of specific groups of people in contact with the criminal justice system, including women offenders, children and young people, young adult offenders and offenders from black and other minority ethnic groups.

BOX 6

Key health data available from Criminal Justice Agencies

- Local reoffending data, such as Police National Computer (PNC) data
- Occurrence of alcohol and drug related crime
- Levels of violent crime and domestic abuse
- Accumulated mental health, emotional wellbeing and drug and alcohol misuse scores from the Offender Assessment System (OASys) database
- Police information regarding mental health markers and numbers of people subject to s.136 of the Mental Health Act
- Drug Interventions Programme (DIP) data relating to class A substance misusing offenders
- Data from criminal justice liaison and diversion services
- Health needs assessment data collected as part of the transfer of commissioning of health services in police custody from individual forces to the NHS
- Prevalence of personality disorder among offenders. Under the Government's new Offender Personality Disorder Strategy, probation trusts, prisons and approved premises are working ever-more closely with health providers to identify, consult and treat personality disorders
- In addition to the above data, a number of probation trusts have also conducted their own local health surveys (including Hertfordshire, Cheshire and Merseyside Probation Trusts).

Build on existing partnership arrangements

As a key leader across the local authority, Directors of Public Health are well placed to co-ordinate activity across multi-agency partnerships brought together to create safer communities. Every local authority is involved in a number of these overlapping partnerships, which offer an opportunity to co-ordinate efforts, and improve outcomes for people in contact with the criminal justice system and the wider community.

BOX 7

Local authority representation in multi-agency partnerships

Community Safety Partnerships
Drug (and Alcohol) Action Teams
Domestic Abuse Strategic Management Boards
Integrated Offender Management
Multi Agency Public Protection Arrangements (MAPPA)
The Multi Agency Risk Assessment Conference (MARAC)
Safeguarding partnerships

iii. Available at: http://homeless.org.uk/sites/default/files/HomelessHealth_PeerActivityToolkit.pdf

BOX 8

Multi-Agency Public Protection Arrangements (MAPPA)

The statutory duties of Directors of Public Health include responsibility for "their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders".[41: p9]

Multi-Agency Public Protection Arrangements were introduced by the Criminal Justice Act 2003 and implemented across the 42 criminal justice areas in England and Wales. The police, the probation service and the prison service are the 'responsible authorities', who, working with a range of other bodies in the local area, are the primary agencies jointly responsible for assessing and managing the risks posed by specified violent and sexual offenders. The legislation provides for a 'duty to co-operate' among a number of bodies in the local area, including local authority housing and social services.

2012 guidance developed by the National Offender Management Service's Offender Management and Public Protection Group outlines the role and duties of local authorities, including advice and the exchange of information in relation to housing and child and adult social services.[iv]

As a member of Health and Wellbeing Boards, Directors of Public Health are ideally placed to raise the profile of health inequalities among people in contact with the criminal justice system and encourage the development of joint initiatives to facilitate pathways into treatment and support, and away from offending. Under the current government plans to extend the range of providers managing offenders in the community (see Box 2) co-ordinated strategies at a local level, such as through JSNAs and JHWSs will become even more important in bringing together a range of agencies and organisations to achieve the overarching aims of improving health and wellbeing outcomes and reducing reoffending.

Through their duty to provide a healthcare public health advice service, Directors of Public Health are also well placed to support Clinical Commissioning Groups in commissioning effective services to improve the health of people in contact with the criminal justice system residing in the local community.

BOX 9

New partners and additional support

While commissioning of public health functions within prisons in England and Wales has been devolved to Health and Justice NHS England specialised commissioners, Public Health England will be working closely with these teams to provide advice and commissioning support across the health improvement, health protection and healthcare public health domains. This support will include:

- Developing the evidence base to support commissioning and service delivery in the prison context
- Development of resources and tools to enable commissioners and service providers to assess the quality and responsiveness of prison based public health services
- Monitor and lead on the control of outbreaks of infectious diseases

At a local level, 10 regional Public Health England justice leads will also be working closely with NHS England Health and Justice commissioners as well as a range of other partners with the aim of improving continuity of care across the prison estate and on release back into the community.

BOX 10

PROMISING PRACTICE EXAMPLE Warwickshire Health and Wellbeing Board

In shadow form, Warwickshire Health and Wellbeing Board launched a public consultation on its initial vision for a Joint Health and Wellbeing Strategy. The consultation explicitly recognised the importance of building a safer community for improving the public health and wellbeing of the local area, and invited consideration on how multi-agency partnerships between criminal justice and health sector actors could be built upon. Supporting horizontal partnerships to tackle anti-social behaviour, domestic abuse, sexual assault, alcohol and substance misuse, and mental health issues are all considered in the Joint Health and Wellbeing Board consultation document.

The shadow Warwickshire Health and Wellbeing Board also invited local criminal justice sector actors, such as Warwickshire Probation Trust, Warwickshire Police and the Prison Service to observe meetings and participate in workshops.

iv. The guidance is available at: http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

Work with others to address common risk factors/determinants of poor health and offending

Key risk factors associated with poor health align closely with key risk factors associated with offending (family breakdown; low educational attainment; low self-esteem; substance misuse; unemployment and homelessness).[44, 45] Targeted interventions that address these shared determinants have the potential to improve health outcomes among people in contact with the criminal justice system and to deliver farther reaching health benefits through reduced reoffending.

The relationship between homelessness and inadequate housing, and poor health outcomes is increasingly recognised,[45, 46] and reflected in the Director of Public Health's responsibilities for reducing statutory homelessness[v]. As emphasised in Public Health England's priorities for 2013/14: "It is at least as important to tackle major non-medical causes of ill-health, like social isolation, homelessness and worklessness".[40: p5] The use of inpatient services among individuals of no fixed abode has been found to be eight times higher than for a comparable age group of the general population, owing to the complexity of presenting health issues among this group.[46] Homelessness has also been linked to poor adherence to treatment for infectious diseases, such as Tuberculosis, which has been found to be concentrated among both homeless and prison populations.[47]

Maintaining and securing housing is a key issue faced by people in contact with the criminal justice system and, alongside the impact on health, homelessness is also found to be linked with increased risk of reoffending. Pre-imprisonment homelessness (including rough sleeping and temporary accommodation in hostels) was reported by 15% of the prison population in a recent large scale survey,[48] while 4% of the general population report ever having been homeless (including rough sleeping or temporary accommodation).[49] Further analysis of these survey findings revealed that prisoners who reported being homeless before entering custody, were much more likely to be reconvicted upon release than those who did not report homelessness as an issue (79% compared with 47% in the first year following release from prison).[49]

Released prisoners who are homeless and who apply for help from their local authority are often not deemed to be in 'priority need', may be considered as 'intentionally homeless', or may struggle to prove a local connection to the area they have returned to and therefore are not offered accommodation.[50] A criminal record can also act to exclude them from housing association, private landlord and supported accommodation providers.[51]

BOX 11

PROMISING PRACTICE EXAMPLE
Merseyside Resettlement Project

The Resettle Project in Merseyside provides a good example of the benefits that can be achieved through jointly commissioned and jointly delivered services involving health and criminal justice.

Their focus is on the challenging group of high risk of harm male offenders, whose risks are linked to their mental health issues, including personality disorders. The service provides an intensive programme of interventions and support which integrate therapeutic work with risk assessment and risk management arrangements in a skilled, multi-disciplinary setting.

While initially commissioned as part of a national programme, the Merseyside-based service is increasingly relevant as part of a wider pathway of more local services, where improving health and wellbeing outcomes is recognised as linked to opportunities to reduce the risks of reoffending and harm to local communities.

Explore opportunities for joint commissioning

Delivering improved outcomes among people in contact with the criminal justice system and reducing reoffending requires a range of strategic partners to come together to develop tailored solutions that respond to local needs. As local areas are given increased flexibility in commissioning across a range of service areas, significant new opportunities for joint commissioning of services are opening up. Police and Crime Commissioners with their responsibilities for reducing crime, offer one such opportunity. Such collaborative approaches are encouraged in Department of Health guidance issued for public health.[39, 41]

The delivery of tailored, flexible services in criminal justice settings, such as in probation delivery units or the new delivery partners following the implementation of Transforming Rehabilitation reforms (see Box 2), can significantly improve engagement with health services among people in contact with the criminal justice system. Compliance with sentence or licence conditions necessitates regular attendance at these premises, and initiatives such as on-site 'drop-in' health centres can ameliorate some of the barriers leading to poor engagement with primary healthcare services in the community.

v. Public Health Outcomes Framework, Indicator 1.15

BOX 12

PROMISING PRACTICE EXAMPLE
Extension of alcohol treatment pathways for offenders in Newcastle

A study by Northumbria Probation Trust of the OASys data collected through the assessment of supervised offenders in the local area highlighted the severe impact that alcohol misuse alone was having on rates of reoffending in Newcastle. Acting upon the findings of this study, Newcastle's Alcohol Strategy Board (chaired by Newcastle's Director of Public Health) and the Safe Newcastle Partnership (local action partnership body of public, private and voluntary sectors) is working closely with the Newcastle Probation Local Delivery Unit to improve pathways for offenders involved in alcohol misuse.

Access to Alcohol Treatment Requirement (ATRs) places in Newcastle for offenders who are dependent drinkers has been doubled, in partnership with addiction services. As demand for ATRs still exceeds capacity, this extra provision has been targeted at those committing violent offences and the most prolific offenders in the city whose offending is linked to alcohol dependence.

Frontline probation staff are also trained to deliver Alcohol Information and Brief Advice (IBA) to offenders with harmful drinking habits, which covers basic advice on how to manage alcohol intake. However, there was recognition that some offenders with alcohol misuse problems but without access to full ATR places would benefit from a more intensive intervention than basic IBA. Therefore an extended alcohol IBA service was commissioned by the Alcohol Strategy Group, which entails specialist alcohol treatment workers holding weekly half day alcohol treatment clinics within local probation teams across Newcastle Local Delivery Unit.

BOX 13

PROMISING PRACTICE EXAMPLE
Lincolnshire Health Support Service

The Lincolnshire Health Support Service was established to improve access to health services by offenders under probation supervision in the local community. Following initial funding by the National Lottery, since 2008 the service has been jointly commissioned by NHS Lincolnshire and Lincolnshire Probation Trust. The project also involves local partnerships with charitable groups (the NOMAD Trust and the Prince's Trust), faith groups, unpaid work groups, approved premise providers, and researchers from the University of Lincoln.

Under the service, all offenders in the local community are given the opportunity to attend a full emotional and physical assessment with a dedicated nurse and health trainer. A broad and holistic approach is taken when assessing the underlying physical, mental, social and economic determinants of health problems that offenders may be experiencing. Clinical and probation staff give personalised advice and motivational support, and will assist offenders in gaining access to the wide variety of local services (from access to GPs and NHS facilities, to help with accommodation and healthy lifestyle support).

Conclusion

The new health commissioning landscape has created an important opportunity to respond to the health needs of the local population including those living at the margins of society. In gaining a full and comprehensive picture to inform local public health strategies, health inequalities among people in contact with the criminal justice system residing in the community must be considered.

Directors of Public Health can be instrumental in delivering significant health improvements among this group. By addressing local health inequalities and improving access to services for those vulnerable to reoffending, this will help tackle one of the main causes behind offending behaviour and simultaneously make progress towards creating safer communities. In turn, a safer community brings wider health benefits to the overall population and reduces strain on local budgets.

Improving public health and wellbeing outcomes cannot be achieved in isolation. Partnerships which bring together housing, health and social care commissioners will be essential to ensure that services across the custody-community commissioning divide deliver integrated pathways into treatment and rehabilitation support. Shared statutory responsibilities and strategic objectives with criminal justice agencies, such as probation trusts and new providers with responsibility for managing offenders in the community from Autumn 2014 onwards, open up significant opportunities for Directors of Public Health to work collaboratively to develop informed, innovative approaches to improving health outcomes and reducing reoffending.

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Revolving Doors Agency
4th Floor, 291-299 Borough High Street, London SE1 IJG
020 7407 0747 | admin@revolving-doors.org.uk | @RevDoors
www.revolving-doors.org.uk

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