Offender Health Pathways

A qualitative study to map offender health and substance misuse pathways across all relevant agencies in North Lincolnshire

Commissioned by North Lincolnshire Public Health

Sally Czabaniuk and Jenny Gavin-Allen, Research and Engagement

October 2013
CONTENTs

1. Introduction and Study Brief 2

2. Methodology 3

3. Background and Policy Landscape 3
   i. Criminal Justice
      a. Police 4
      b. Courts 6
      c. Person Escort Records 6
      d. Probation and Resettlement 8
      e. Liaison and Diversion 10
   ii. Health 12
      f. Mental Health 14
      g. Learning Disability 18
      h. Dual Diagnosis 19
      i. Substance Misuse 21
   iii. Women 22
   iv. Black and Minority Ethnic (BME) Groups 24

4. Findings:
   4.1. Early Intervention and Police Custody
      i. Literature Review 26
      ii. Stakeholder Engagement 35
   4.2. Courts and Diversion
      i. Literature Review 39
      ii. Stakeholder Engagement 45
   4.3. Probation and Community Sentences
      i. Literature Review 48
      ii. Stakeholder Engagement 54
   4.4. Resettlement
      i. Literature Review 59
      ii. Stakeholder Engagement 68
   4.5. Stakeholder Engagement on Key vulnerable groups
      i. Women Offenders 72
      ii. Offenders from BME backgrounds 74
      iii. Offenders with Mental Health problems 75
      iv. Offenders with Learning Disabilities 76
      v. Offenders with Dual Diagnosis 76

5. Conclusions:
   5.1. Improving the efficiency and effectiveness of systems 77
   5.2. Working in partnership 78
   5.3. Improving capacity and capability 79
   5.4. Equity of access to services 80
   5.5. Improving care pathways and continuity of care 81

6. Recommendations 81

APPENDIX 1 - Stakeholder Event Breakout Sessions
Offender Health Pathways

A Qualitative Study to Map Offender Health and Substance Misuse Pathways across all Relevant Agencies in North Lincolnshire.

1. Introduction and Project Brief

There is strong evidence to demonstrate disproportionate levels of mental and physical ill health within the offender community. Offenders invariably struggle to access health care services, particularly primary care, which is the gateway to specialist services such as mental health and substance misuse services. For many offenders the first time they meet health and social care professionals occurs when they enter the criminal justice system.

The North Lincolnshire Joint Strategic Needs Assessment (JSNA) provides an assessment of the health and social needs of the North Lincolnshire population to inform priorities for the Health and Well Being Strategy and the commissioning of services. This study is commissioned by North Lincolnshire Public Health that identified offender health as presenting a critical data-hiatus in the North Lincolnshire JSNA.

The objectives of this study are:

(a) to map how formally discrete agencies - namely the NHS, the probation service, the police and the voluntary sector - interact along the offender health pathways and,

(b) to explore this journey for offenders, post-sentence, in the community. Specifically, an emphasis has been placed on the following sub-groups: women, people with mental health problems; people with learning disabilities; black and minority ethnic groups and those who have a dual diagnosis.

It follows that this study seeks to establish, as accurately as possible, the current position. From this, current and likely future challenges and opportunities for working can be identified. In this process, use has been made of the five objectives from ‘Improving Health, Supporting Justice’¹, namely:

- improving the efficiency and effectiveness of systems
- working in partnership
- improving capacity and capability
- equity of access to services, and
- improving care pathways and continuity of care

2. Methodology

To meet the required objectives, the study was carried out in three stages:

i. A comprehensive literature review of relevant existing evidence in the area, current policy and best practice elsewhere. The review references a quantity of research and policy documents. Researchers also attended the Royal College of General Practitioners and Leeds Community Healthcare NHS Trust Offender Health conference in March 2013, which explored the commissioning environment for offender health.

ii. Individual interviews and focus groups with relevant agencies and offender health commissioners to carry out initial scoping work.

iii. A stakeholder event bringing together all relevant agencies to work together in order to map the pathways for offenders and to identify gaps, challenges and opportunities for future working. A total of 34 representatives from 21 organisations took part in this event. During the event, initial findings from the literature review and interviews were shared with delegates who were then invited to contribute to workshop sessions looking at each of the identified vulnerable offender groups. The workshop sessions required delegates to map their organisation’s involvement in supporting the health and wellbeing of offenders in a range of scenarios.

A ‘task and finish’ Steering Group comprising 14 key stakeholders was established to oversee the study. The role of the Steering Group is to:

- Agree the protocol and scope of the mapping exercise;
- Oversee the design, planning, delivery and evaluation of the North Lincolnshire Offender Health Mapping process;
- Frame the outcomes and recommendations with stakeholders to shape and improve services and inform the Health and Wellbeing Board; and
- Encourage and facilitate the involvement of all stakeholder organisations in the North Lincolnshire Offender Health Mapping exercise.

The initial project brief called for a focus on resettlement pathways specifically. The Steering Group, however, requested that this be extended to include all stages in the offender’s journey through the criminal justice system apart from, and precluding, prison establishments.

3. Background and Policy Landscape

This report has been undertaken during a period of radical change to the public service landscape in general and with specific regard to this review, a corresponding raft of measures has been (or is being) brought into law that impacts on the current and future development of offender health service provision.

Against a backdrop of policy and legislative change is the government’s deficit reduction programme with budget cuts across all public services, re-organising, reducing or cutting programmes and impacting on all aspects of our communities.
The Welfare Reform Act 2012\textsuperscript{2} introduced the 'Universal Credit' to replace a range of existing means-tested benefits and tax credits for people of working age, to take effect from 2013.

Besides introducing the Universal Credit, the Bill made other significant changes to the benefits system:

- introduction of Personal Independence Payments to replace the current Disability Living Allowance
- restriction of Housing Benefit entitlement for social housing tenants whose accommodation is larger than they need
- up-rating of Local Housing Allowance rates by the Consumer Price Index
- amending the forthcoming statutory child maintenance scheme
- limiting the payment of contributory Employment and Support Allowance to a 12-month period
- capping the total amount of benefit that can be claimed.

The potential impact of these changes on offenders and potential offenders is not clear. We do know, however, that two-thirds of prisoners were unemployed in the four weeks before imprisonment and nearly three-quarters of prisoners were in receipt of benefits immediately before entering prison.

Within this cyclone of policy and research there are a number of highly significant changes that are bound to impact on the provision of health and support services within the criminal justice system, besides the wider community. This restructuring provides a number of challenges and opportunities for local, regional and national agencies. The new structures of health and justice delivery could provide increased opportunities for offender health care to be planned and implemented to complement each other’s activities with greater efficiency and cost-effectiveness and to effect improvements in the overall provision of offender health services.

Over several decades of research, there is little argument that offenders typically have proportionately greater health needs than the population as a whole, yet have below average engagement with NHS services. Furthermore, contact with the Criminal Justice System - especially when in custody - not only exacerbates existing problems, but also increases vulnerability to the onset of mental health issues. These issues of disproportionate incidence and vulnerability to poor health remain within the Criminal Justice System for historical reasons and it is pertinent to consider here the range of policy and research that has attempted to rectify this situation.

A series of high profile reports have been published, which provide an authoritative case for addressing the health needs of offenders and developing more effective services for them. In acknowledging and delivering on the wider benefits which accrue from reduced health inequalities; community safety and social cohesion can be vastly improved. This section considers the policy and legislation that populate the offender health landscape and influence current practice.

\begin{itemize}
\item \textbf{Criminal Justice}
\item \textbf{Police}
\end{itemize}

\footnote{1 Welfare Reform Act 2013 c.5}
policing. Part 1 abolished Police Authorities and replaced them with directly elected Police and Crime Commissioners (PCCs) serving four-year terms and in November 2012, the first of these elections was held in each of the former Police Authority areas.

The elected Commissioners have a broad range of powers, subject only to limited scrutiny by newly created Police and Crime Panels. Elected Commissioners are responsible for securing the maintenance of the police force and setting the local area policing plan and budget. Moreover, they have the power to hire and fire the Chief Constable.

Police authorities, which formerly held police forces to account, were abolished from November 2012.

PCCs are also responsible for funding community safety activity to tackle crime and disorder by making grants to organisations that support their objectives. The Home Office intends to consolidate and transfer some existing grants for community safety and drug interventions to PCCs from 2013/14. The Community Safety Fund (formerly within the Area Based Grant) had already been reduced by 20% in 2011/12 and was reduced by a further 40% in 2012/13, before being transferred from local authorities to PCCs from 2013/14. In England, PCCs will also receive funding for services to address violence against women and girls and a proportion of Drug Interventions Programme Funding, with the remainder going to new Health and Wellbeing Boards.

Until recently in England, the commissioning of health care services for those detained in police custody has been the responsibility of the police. In accordance with the Police and Criminal Evidence Act 1984 (PACE), the focus of this health care has been to ensure that detainees are fit to be detained and interviewed and to provide forensic evidence. Growing concerns around the poor health outcomes of those who offend and the incidence of self-harm and death whilst in custody has led to a shift in policy, with a growing consensus that, as prison healthcare has been transferred to the NHS, healthcare in police custody should also be commissioned through NHS commissioning structures.

The Police and Criminal Evidence Act 1984 (PACE) established “...the powers of the police to combat crimes while protecting the rights of the public”. It attempts to “strike the right balance between the powers of the police and the rights and freedoms of the public”.

The PACE codes of practice cover:

- stop and search
- arrest
- detention
- investigation
- identification
- interviewing detainees

Following consultation (published in November 2011), revised versions of PACE codes have come into effect. The following revisions concern the health and welfare of detainees:

- allowing the custody officer to direct custody staff to carry out certain actions in relation to a detainee’s rights and entitlements, need for medical treatment and the risk assessment process

---

4 A further round of PACE consultation which ran from March to May 2013, covers revisions to the stop and search, searching premises and the audio and visual recording of interviews powers.
• allowing those in whose welfare the detainee has an interest to visit her/him
• updated provisions on the self-administration of controlled drugs and the application of safeguards for detainees suspected of being under the influence of drink or drugs or both

Where a mental disorder or any other health need is identified, custody officers have a statutory responsibility to arrange for appropriate clinical attention “as soon as reasonably practicable”. This is required “even if the detainee makes no request for clinical attention” (Home Office, 2008, p.29).

b. Courts
Since 1327, when the first Justices of the Peace were appointed by parliamentary statute, England has formally developed its judicial systems through Acts of Parliament. It was not until 1907, however, with the passing of the Criminal Appeal Act, that the accused had a right to appeal against criminal convictions.

Immediately post the Great War, 1919 saw the introduction of female Justices of the Peace with the Sex Disqualification (Removal) Act and Legal Aid was established through the 1949 Legal Aid and Advice Act with the 1971 Courts Act abolishing courts of assize and quarter sessions, replacing them with crown courts.

The 2003 Courts Act linked together the administration of all parts of the judicial system under a newly created body: Her Majesty’s Courts Service.

The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 which received Royal assent on 1 May 2012, introduces a wide range of reforms to the justice system as well as delivering structural reforms to the administration of legal aid. The Act also contains a number of new measures to protect the public and reduce reoffending, including:

• Creating a new youth remand and sentencing structure, which gives more flexibility to courts to decide on appropriate disposals
• Creating tougher community sentences with longer curfews for offenders
• Reforming the Rehabilitation of Offenders Act, to help ex-offenders reintegrate into society after their sentences.
• Creating a tough new sentencing regime to replace the inconsistent Imprisonment for Public Protection (IPP) sentence.

There is also provision within the Act for police officers to give ‘out-of-court disposals’ and these powers came into effect on 8th April 2013.

c. Person Escort Records
A Person Escort Record (PER) is the main vehicle for conveying information about a detainee’s risk of self-harm, and is used as that detainee moves between police custody, court, prison and other locations. The PER, therefore, is a crucial part of how the state fulfils its duty of care for vulnerable people in custody.

5 http://www.parliament.uk/about/living-heritage/transformingsociety/laworder/court
6 The Legal Aid, Sentencing and Punishment of Offenders, Ministry of Justice May 2012
A redesigned PER, issued in 2009 and implemented during 2010\(^7\), provides detailed guidance on the use of the revised PER specifying that:

‘...the PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of prisoners. The form highlights the risks posed by and the vulnerability of prisoners on external movement, provides assurance that the risks and weaknesses have been identified and communicated to those who are responsible for the prisoner and provides a record of events during a prisoner’s movement.’

HM Inspectorate of Prisons report on the use of PERs with detainees at risk of self-harm\(^8\) was initiated at the request of the Independent Advisory Panel of the Ministerial Board on Deaths in Custody.

The issues that emerge from the report echo the findings from other settings - where different agencies have to co-operate to fulfil a duty of care:

“...maintaining quality in large-scale processes where risks might be infrequent but serious for the individuals concerned, and ensuring communication between the operational staff involved is effective and informed by a good understanding of each others’ needs”.

Following the publication of Lord Bradley’s review in 2009, the government established the Health and Criminal Justice Programme Board which brought together government departments and agencies across health, social care and criminal justice. Tasked with developing a national delivery plan to implement Bradley’s recommendations, including the development of liaison and diversion services, the board published ‘Improving Health, Supporting Justice’\(^9\), later that year.

In their response to the Bradley Report, the government accepted almost all of the recommendations either in full or in principle. A summary of the most relevant within the context of this study is as follows:

- Local Safer Neighbourhood Teams should play a key role in identifying and supporting people in the community with mental health problems or learning disabilities;
- All police custody suites should have access to liaison and diversion services which in turn provide information and advice services to all relevant staff;
- The NHS and police should explore the feasibility of transferring commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS.
- Courts, health services, the Probation Service and the CPS should work together to agree a local Service Level Agreement for the provision of psychiatric reports and advice to the courts;
- Clearer guidance on the use of Mental Health Treatment Requirements and the development of Service Level Agreements to ensure the necessary requirements are available, and
- Appropriate training for staff at all stages of the CJS.

The Health and Criminal Justice Board took this work forward as a joint initiative between the Department of Health, Department for Children Schools and Families, Ministry of

\(^7\) Communicating Information About Risks on Escort or Transfer - The Person Escort Record (PER), Prison Service Order 1025, 2009

\(^8\) The use of the person escort record with detainees at risk of self-harm, Thematic report by HM Inspectorate of Prisons, October 2012

\(^9\) Improving Health Supporting Justice, Department of Health, 2009a
Justice, Youth Justice Board and the Home Office and published Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board in November 2009. The plan states: “Prevention and early intervention (coupled with system reform to deliver better information sharing and close working between criminal justice agencies and the NHS - through embedding offender health in World Class Commissioning, for example) must inform our focus as we move forwards.”

The incoming coalition government of 2010 maintained this drive forwards, particularly in relation to the roll-out of liaison and diversion schemes. The October 2010 Spending Review document provided a clear statement of intent: “The Government will...take forward proposals to invest in mental health liaison services at police stations and courts to intervene at an early stage, diverting mentally ill offenders away from the justice system and into treatment”.

The Offender Rehabilitation Bill 2013/2014; went through its second reading stage in May 2013. The bill makes provision to increase support and supervision on release for those serving a sentence of less than two years and proposes to make a number of changes to the arrangements for community orders and suspended sentence orders. The bill also expands the potential use of post-release conditions to combat drug misuse.

d. Probation and Resettlement
Probation has essentially worked with offenders whose crime is not serious enough to warrant a custodial sentence, and those recently released from custody to minimise the risk of re-offending. The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. The Probation Service was established in England in its current form by the Criminal Justice and Court Services Act in April 2001, but has existed since 1907 as a group of area based services interacting at arms-length with central government.

Resettlement refers to the process whereby prisoners and their families receive assistance and support from the Prisons and Probation Services, and voluntary agencies to help them prepare for life after prison. This includes:
- advice about their entitlement to state benefits
- training and education
- work experience, and
- preparation for release (including finding accommodation)

The objective is to help prisoners return to normal life, get a job and home, and cope with life without re-offending.

The probation service began in the 1870s when the Church of England Temperance Society recognised a problem with repeat offending and established the London Police Court Mission. In the next decade the mission opened homes and shelters and in 1907 the Probation Service was formally established as a result of the Probation of Offenders Act. This gave the missionaries official status as “officers of the court” and allowed courts to suspend punishment and discharge offenders if they entered into a ‘recognisance’ of between one and three years. One condition of this ‘recognisance’ was supervision by a

11 Spending Review 2010, HM Treasury, October 2010
12 http://services.parliament.uk/bills/2013-14/offenderrehabilitation.html
person named in a “probation order”. Between 1910 and 1930 the prison population halved with probation playing a major part in this.

The 1925 Criminal Justice Act established probation committees and the appointment of probation officers became a requirement of the courts. In 1938 The Home Office assumed control of the probation service and introduced a wide range of modernising reforms. The legal formula of “entering into a recognisance” was replaced by “consent to probation”. Requirements for psychiatric treatment were also introduced and it was made mandatory for female probationers to be supervised by women officers.

The 1948 Criminal Justice Act introduced prison after-care and provided for funding of Probation Homes and Hostels. It also incorporated punitive measures such as attendance centres and detention centres, but the stated purpose of the probation order remained intact and was reaffirmed as “advise, assist and befriend”. Community Service Orders were introduced in 1972 and designed to be punitive in depriving the offender of leisure time, but constructive in benefiting the community and changing the offender’s outlook.

During 1980, the Carlisle Review of Parole proposed a coherent system for supervised early release from prison and an Audit Commission Review produced a framework for probation intervention. This resulted in the introduction of cautioning schemes, alternatives to custody and crime reduction, while changes in sentencing resulted in the development of day centres, special programme conditions, the probation order as a sentence, and risk of custody and risk of reconviction assessment tools.

The Criminal Justice Act 1991 gave the Probation Service the lead on all manner of new community sentences and in 1998 further legislative changes were introduced, including drug testing orders, new youth justice provision and electronic tagging.

The Criminal Justice and Court Services Act of 2000 renamed the probation service as the National Probation Service for England and Wales, replacing 54 probation committees with 42 local probation boards and establishing 100% Home Office funding for the probation service. In 2001, the 54 probation areas were reduced to 42 to achieve co-terminosity with other criminal justice agencies. In 2002, Multi-Agency Public Protection Arrangements (MAPPA) came into force, placing a responsibility on probation staff, in partnership with the police, prison service and others, to protect the public from sexual and violent offenders.

In 2004 the government published Reducing Crime - Changing Lives, aimed at improving the effectiveness of the criminal justice system and the correctional services in particular. The National Offender Management Service (NOMS) was established with the aim of reducing reoffending through more consistent and effective offender management. The government also proposed introducing commissioning and contestability into the provision of probation services, which aimed to drive up standards further among existing providers and to enable new providers to deliver services.

The most significant reforms to probation were set out in the government’s consultation document; Transforming Rehabilitation - less crime, fewer victims, safer communities. Under plans laid out in the consultation, a refocused public sector service is expected to work with the most dangerous and high-risk offenders, whilst private and voluntary sector organisations would work with the ‘revolving door’, lower risk offenders.

---

13 Transforming Rehabilitation - less crime, fewer victims, safer communities, Ministry of Justice, January 2013
For the first time all offenders - including those serving less than 12 months - will be subject to mandatory supervision and tailored rehabilitation on release from prison. The proposals call for a greater use of mentors who will meet offenders at the prison gate, supporting them in all aspects of their life, including helping them in finding work and accommodation, tackling drug and alcohol addictions and addressing literacy and educational problems.

e. Liaison and Diversion
Liaison and diversion services are designed to divert people with mental illness away from the criminal justice system.

As far back as 1777 John Howard (a philanthropist and the first prison reformer) identified that people with mental illness were being detained inappropriately in prison. In 1990, the Home Office reminded courts of their existing powers to divert mentally disordered offenders away from the Criminal Justice System, stating that, “where no public interest is served by pursuing a conviction for a minor offence, people with mental illness should instead be channeled into treatment services with the primary aim of improving their health”.

The circular also stated that “a mentally disordered person should never be remanded to prison simply to receive medical treatment or assessment”, thereby indicating a clear need for processes and systems to facilitate an early assessment of mental health needs.

A measure of the difficulty encountered in fully understanding and implementing these powers is that the circular did not describe any new or extended powers but sought to remind the judiciary and magistracy of their existing responsibilities to ensure people with a mental disorder were diverted appropriately.

The Reed Review of Health and Social Services for Mentally Disordered Offenders in 1992, called for nationwide provision of court assessment and diversion services. Liaison and diversion services were set up in a number of areas following this; however, a lack of any centralised strategy or guidance meant provision was patchy and inconsistent. The provision thus remained fragmented.

The Social Exclusion Unit’s report, Reducing Reoffending by Ex-Prisoners in 2002 identified nine key factors in re-offending; including “drug and alcohol misuse” and “mental and physical health” and informed the development of new Public Service Agreements (PSAs) for 2008-2011.

Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system, published in 2009, highlighted a number of key issues with regard to liaison and diversion:

- the need for a positive approach to the individual needs of patients, many of whom, including women and people from ethnic minorities, may have special or differing needs;
- a flexible, multi-agency and multi-professional approach to identify and meet most effectively the needs of mentally disordered offenders;

---

14 Home Office Circular 66/90
15 Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services, Reed, HMSO, 1992
16 Reducing re-offending by ex-prisoners, Social Exclusion Unit, HMG Cabinet Office July 2002
17 The Bradley Report, Department of Health, 2009
improved access to more specialised services in mental health and learning disability services, and recognition of the role played by more general services in providing care and treatment for most mentally disordered offenders, and
the need for a closer working between the police, health and social services to avoid unnecessary prosecution of mentally disordered suspects.

The Bradley Report, which drew on research undertaken by NACRO, suggested that there were around 143 Criminal Justice Liaison and Diversion (CJLD) schemes in England and Wales whereas Dr Wendy Dyer in her report of 2011 reported that there were 335 magistrates’ courts in England, highlighting the concern that only one third of courts had access to CJLD teams.

Bradley identified four broad models of scheme:

- **Diversion** - to increase the identification of mental illness and facilitate and accelerate transfer to hospital where appropriate
- **Assessment** - more focus on identifying and assessing people appearing before the courts, in order to assist magistrates with disposal options
- **Liaison** - offer support and liaison both to people with mental health problems and to the agencies involved with them, so as to ensure they are treated appropriately
- **Panel** - formally bringing together a range of agencies - police, health, social care and probation - to put forward a co-ordinated package of care for the courts or Crown Prosecution Service (CPS) to consider. They also co-opted other agencies and organisations, such as third sector organisations, housing services and drug services.

A key message of the Bradley Report was to promote the role of liaison and diversion services earlier in the Criminal Justice System; operating at the police stage to identify offender’s mental health problems and learning disability earlier. His vision for liaison and diversion has influenced current policy and helped to move liaison and diversion services to centre stage in offender health policy, forming part of the government’s ‘rehabilitation revolution’, outlined in the Green Paper, ‘Breaking the Cycle’. It is now government policy to pilot and roll-out liaison and diversion services nationally by 2014.

In 2009, the Criminal Justice Joint Inspection into work with offenders prior to sentencing found strong evidence of a twin-track approach with: “…little appetite for increasing the numbers diverted from prosecution...concerns remained however, about the engagement of the health service and subsequent availability of treatment for the many offenders who had low-level mental health issues.”

Addressing the health needs of offenders in the community both pre and post-sentencing is an area that has been overlooked at local level when planning and commissioning services. Joint Strategic Needs Assessments (JSNAs) and strategic commissioning plans have frequently overlooked the needs of offenders despite their acknowledged mental health problems and/or learning difficulties.

Within New Horizons: A Shared Vision for Mental Health, published in December 2009 there was recognition that effective CJLD service provision provides an opportunity to identify those in need of mental health support, who may not otherwise be, or become known to, community mental health teams. It also considered that the role of CJLD

---

18 Dyer, 2011, p.5
20 Ministry of Justice, 2010
services can help to address concerns regarding access to treatment, the need for culturally sensitive provision and an increased analysis of the impact of gender.

In January 2012, the Minister of State for care services announced a significant increase in funding for liaison and diversion services for 2012/13; viz. £19.4million compared to £5million for the previous year. In his statement, the Minister said: “Liaison and diversion services aim to ensure that wherever offenders are in the criminal justice system, their health needs or vulnerabilities are identified and assessed and they are linked to appropriate treatment services” and that they would be “accessible to all offenders - whether adult men or women, children and young people, and whether they have a mental health or substance misuse problem, learning disability or personality disorder.”

This was seen as particularly important by agencies such as Revolving Doors. They welcomed the announcement, especially for, “individuals who traditionally find it hard to get help, including people with mental health problems which fall below the threshold for statutory mental health services, those who experience mental health problems at the same time as drug or alcohol issues, and young adults making the transition from young people’s to adult services.”

Despite this support, it is still unclear the precise form that liaison and diversion schemes would take. The National Pathfinder Scheme, as well as the Big Diversion project in the North East, aims to develop evidence of good practice and service specifications for services going forward, to contribute to the ongoing development of these services.

In March 2012, the Government published a Mental Health strategy, ‘No Health Without Mental Health’, signalling a clear commitment to improving the nation’s mental health and to improving the life chances of those who have mental health problems. Mental Health professionals welcomed the strategy for its pledge to develop diversion services, to extend the availability of psychological therapies to more people and its commitment to promoting mental health for people of all ages.

The challenge has been to put the Government’s vision into action, and to this end leading mental health organisations have worked together to produce a framework for the implementation of the strategy. The framework, launched by the Deputy Prime Minister in July 2012, set out the steps required to achieve the strategy’s objectives as well as introducing a new mental health dashboard to show overall progress.

ii. Health

Since coming to power in 2010, the coalition government has embarked on a large-scale reorganisation of the National Health Service (NHS). Primary Care Trusts and Strategic Health Authorities are replaced by clusters of GP practices known as Clinical Commissioning Groups (CCGs) which take on their commissioning powers. The Health and Social Care Act 2012 placed accountability for CCGs with the new national NHS Commissioning Board.

---

22 Hansard HC Deb 12 January 2012, C22WS
24 No Health Without Mental Health, DOH, 2011
Responsibility for public health has been transferred from the NHS to local authorities, funded by a ring-fenced public health budget. This includes a transfer of responsibility for substance misuse services. All upper-tier local authorities are now responsible for setting up statutory Health and Wellbeing Boards, formed to include the director of public health; locally elected councillors and representatives of local Clinical Commissioning Groups; children’s services; adult social services, and a local Health Watch - a new independent organisation representing the views of the public. Local authorities can invite additional members to join the board, although there is no obligation to widen membership.

The main aim of Health and Wellbeing Boards (HWBs) is to improve outcomes in health care and wellbeing. Improving mental health will be a key component of this responsibility. Each HWB is responsible for the development of the local Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy. HWBs also have a key role in joining up commissioning across health and social care, although their agenda extends to wider issues impacting on health -- including housing, education and the environment.

The Health and Social Care Act 2012 has also paved the way for increased competition in health services. It has enabled private sector companies and charities to compete with the public sector to provide NHS services, enabling patients to receive treatment from “any qualified provider”.

The commissioning of most local health services, including mental health services, is delegated to Clinical Commissioning Groups. Section 15 of the Act, however, requires the NHS Commissioning Board to commission certain services. These include “services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description” and is effective from April 2013 (although transition arrangements will not be completed until 2014; see table below).

### Transition of new health commissioning responsibilities to the NHS:

<table>
<thead>
<tr>
<th>Accommodation</th>
<th>Current/Transitional Commissioner</th>
<th>Commissioning Responsibility from 2013/14</th>
<th>Approximate Resources 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisons and Young Offenders Institutions</td>
<td>NHS/NOMS</td>
<td>NHS</td>
<td>£470m</td>
</tr>
<tr>
<td>Secure Children’s Homes</td>
<td>NHS</td>
<td>NHS</td>
<td>£1.4m</td>
</tr>
<tr>
<td>Secure Training Centres</td>
<td>Youth Justice Board</td>
<td>NHS</td>
<td>TBC</td>
</tr>
<tr>
<td>Immigration Removal Centres</td>
<td>UK Borders Agency</td>
<td>Mid-Transition to NHS</td>
<td>£6m</td>
</tr>
<tr>
<td>Police Custody Suites</td>
<td>Individual Police Forces</td>
<td>Mid-Transition to NHS</td>
<td>£66m</td>
</tr>
<tr>
<td>Courts (Liaison and Diversion Services)</td>
<td>DH Funded</td>
<td>NHS</td>
<td>£19.4m</td>
</tr>
</tbody>
</table>

*Source: Securing Excellence in Commissioning for Offender Health, NHS Commissioning Board, February 2013*

One of these responsibilities is to directly commission health services or facilities for offender health services in prisons, police custody, criminal justice liaison and diversion services and for victims of sexual assault.

The rationale for including Sexual Assault Services within these responsibilities rests on the close alignment required between the NHS and Police to address both the patient’s
health needs and the forensic enquiry necessary to support criminal investigation. Unlike the funding for healthcare in prisons, these services are funded through a public health budget.

The responsibility for raising the standard of healthcare delivered to offenders across the Criminal Justice System is now devolved to Offender Health, a team which spans the Department of Health and the Ministry of Justice as well as other key departments.

a. **Mental Health**

Since 1800, there have been many attempts to legislate for the assessment and care of those with a mental disorder as it had become clear that a specific legal framework for medical treatment was needed in order to balance the rights of detained persons and the safety of the public.

The Criminal Lunatics Act (1800) established a set procedure for the indefinite detention of mentally ill offenders. It was passed as a direct reaction to the trial of James Hadfield, who had attempted to assassinate King George III. Before 1800, if a defendant was acquitted on the grounds of insanity, s/he was allowed to go free as there was no law in place that allowed for detention. Following the Act criminals who were found to be insane were admitted to London’s Bethlem Hospital (‘Bedlam’).

The Criminal Lunatics Asylum Act (1860) established the first separate special asylum: Broadmoor Hospital in Berkshire under the responsibility of the Home Office, and subsequently Rampton and Moss Side Hospitals. With the establishment of the National Health Service in 1948 the ownership of these high-security hospitals was transferred to the then Ministry of Health. However, the Home Office continued to control the admission and discharge of patients at Broadmoor Hospital.

Following the introduction of the Mental Health Act in 1959, the Department of Health became the manager of all three hospitals and controlled admissions to them, with the Home Office retaining control over the detention of restricted patients.

Today, the Home Secretary oversees the treatment of mentally disordered offenders subject to restriction orders, restriction directions or hospital directions under the Mental Health Act 1983. The Mental Health Act 1983 covers the reception, care and treatment of mentally disordered persons and the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and be assessed or treated against their wishes, unofficially known as “sectioning”. ‘Mental disorder’ is defined within the Act as: 

“...covering affective disorders, psychotic disorders, personality disorders and learning disability.”

The Act was significantly amended in 1995 and 2007, and the Mental Health Act 2007 also amended the Mental Capacity Act 2005 and the Domestic Violence Crime and Victims Act 2004. The major amendments impacting on offender health are:

---

26 The Mental Health Act, Department of Health, 1983
27 The Mental Health Act, Department of Health, 2007
28 The Mental Capacity Act, Department of Health, 2005
29 Domestic Violence, Crime and Victims Act, Ministry of Justice, 2004
• Hospital direction patients can no longer apply to Tribunal during the first six months
• Conditionally-discharged hospital direction patients can be absolutely discharged by a Mental Health Treatment Requirement (MHRT)
• Restriction orders can no longer be time-limited
• Domestic Violence Crime and Victims Act 2004 applies to unrestricted criminal patients
• Higher penalties for offences under the Act
• Patients can be transferred between places of safety under sections 135 and 136.

Section 135 and 136
Sections 135 and 136 of the Mental Health Act 1983 cover police involvement in detaining people with a mental health need for assessment. These sections of the Act call for joint-working involving a number of agencies, but most particularly between police and health.

Section 135 (1) of the Mental Health Act 1983 allows police, accompanied by an Approved Mental Health Professional (AMHP) and a doctor, to enter a locked private premises and remove a person suffering from a mental disorder to a place of safety for assessment. This is a planned intervention and requires a magistrate’s warrant.

Section 135 (2) relates to police retaking somebody previously detained under the Mental Health Act, but who has gone Absent without Leave.

Section 136 empowers a police officer to remove somebody who appears to be suffering from a mental disorder and is in immediate need of care and control from a public place to a place of safety.

Although in force since the Mental Health Act of 1983, there are a number of concerns over the use of both Sections, but predominantly the inappropriate use of s.136 (s.135 is a planned intervention requiring a warrant and is therefore used less frequently).

The inappropriate use of s.136 is seen to occur as a result of a number of issues:

• lack of alternative community options
• lack of police knowledge of alternative options where they do exist
• inadequate police training around the use of the section
• regarding and using of police custody as a “place of safety”.

Whilst the Act does allow for the use of police custody as a place of safety in certain circumstances, there is concern that this can have the effect of criminalising someone whose primary need is medical. It is self-evident that being in police custody engenders a level of stress and anxiety that is highly likely to exacerbate the situation.

There is specific guidance within the Act on transport and Places of Safety:

Transport
• “Patients should always be conveyed in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people.”
• An ambulance or other hospital transfer is the preferred mode of transport in most circumstances
• The police must conduct a risk assessment to decide whether a police escort is required for the ambulance, or if the police officer should accompany the detainee in the ambulance.
• If a police vehicle is used, a member of the ambulance crew can be asked to be present in the vehicle or have an ambulance follow behind in case of a medical emergency

• Moves between places of safety may only occur in the interests of the patient and not for expedient operational reasons.

Places of safety

• Where a detainee’s behaviour “would pose an unmanageably high risk to other patients, staff, or users of a healthcare setting...a police station should be used as a place of safety only on an exceptional basis.”

• Where a hospital setting is not available, the police station should not be an automatic second choice: “Other available options, such as a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily, should also be considered.”

The National Policing Improvement Agency (NPIA) guidance states that: “All forces should have access to suitable non-police places of safety, and that co-operation between police and healthcare trusts is needed to ensure that these are adequately resourced.”

Section 12 of the Mental Health Act requires that, wherever possible, assessment should be undertaken by a doctor approved under that section of the Act; and where this is not possible, the reason for the practitioner’s absence should be recorded. Assessment should take place as soon as possible in the place of safety. No time limit is specified, other than it should be within the 72-hour limit for detention under the section. However, the Royal College of Psychiatrists suggests that assessment should begin within three hours where clinically appropriate.

The Reed report on mentally disordered offenders was a joint review by the Home Office and Department of Health. The committee, chaired by Dr John Reed, senior principal medical officer at the Department of Health, began its work in January 1991 and the final report made 276 recommendations. An article in the British Medical Journal in December 1992 stated: “Underlying Reed’s report are clinical scenarios for which medical responses are rarely adequate. When the police apprehend a disturbed young man suffering from schizophrenia what action might they reasonably expect from medical agencies? How long should a psychotic offender, remanded in prison for a psychiatric report, wait until a psychiatrist for the catchment area comes to see him? When a patient detained in a special hospital is considered ready for transfer to another hospital how long should he have to wait before it takes place?”

Reed proposed that these and other needs could be met only by a broad and integrated range of health and social services. Reed identified a set of principles to maximise rehabilitation or opportunities for independent living:

• high quality care
• provided by health and social services (not in the criminal justice system)
• according to individual need
• near to the patient's home or family
• as far as possible in the community but otherwise in conditions of no greater security than is justified

30 National Policing Improvement Agency Guidance, 2010
31 Review of health and social services for mentally disordered offenders and others requiring similar services, Department of Health, Home Office, 1992
32 BMJ Volume 305 12 December 1992
• multi-agency approach and local ownership of services

The Reed review considered that an improvement of mental health services for prisoners could be attained by contracting in services from the NHS. In 1996 HM Chief Inspector of Prisons published the report: ‘Patient or Prisoner?’, and this was followed by The Future Organisation of Prison Healthcare in 1999. This started the process of transferring budgeting and commissioning responsibility for health services from the Prison Service to the NHS, which was completed in April 2006.

The commissioning of services for the prison population by the NHS and particularly primary care trusts, helped to highlight health issues in other areas of the criminal justice system.

Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons 2001, set out a joint Department of Health and Prison Service approach to development and modernisation of mental health services in prisons. In line with the National Service Framework for Mental Health and the NHS Plan it set out the future development of prison mental health services so that services more closely matched those available in the community.

The Mental Health of Prisoners: in 2007 again raised the profile of prisoners and their mental health needs, and made recommendations for better provision of diversion schemes and improvements in mental health services provided to prisoners.

In the same year Baroness Corston’s report, which focussed on women in the criminal justice system with mental health problems and learning disabilities, was published. In addition to considering the problems experienced by women in custody, Baroness Corston highlighted the need to take a broader view and consider the reasons and circumstances which lead women to enter the criminal justice system. She argued for a more proportionate response and gender-specific alternatives to custody for women, especially community-based options as more effective and cheaper. She advocated for a comprehensive rethink to provide a “distinct, radically different, visibly-led, strategic, woman-centred, integrated approach” to dealing with women in custody.

Published a month before the Equality Act 2007 came into being, Corston noted the apparent lack of preparation within the Criminal Justice System to be prepared for the new duties the Act would impose on it.

Paying homage to both the Reed and Corston reports, Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice detailed 82 recommendations for agencies working with offenders with mental health and learning disabilities. The recommendations sat within five overarching themes:

---

34 Joint Prison Service and National Health Service Executive, Working Group, March 1999
35 Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons, Department of Health, 2001
36 National Service Framework for Mental Health, Department of Health, 1999
38 The Corston Report; A review of women with particular vulnerabilities in the criminal justice system, Home Office, 2007
39 The Bradley Report, Department of Health, 2009
early intervention
arrest and prosecution
the court process
prison, community sentences and resettlement, and
delivering change through partnership.

The report highlighted the police stage as one of the least developed in the offender pathway in terms of engagement with health and social services and identified a need to explore placing responsibility for better identification and assessment at the start of the offender pathway. He identified the reliance by the Crown Prosecution Service (CPS) on police information when making decisions on charging or diversion and the reliance on probation staff in courts to identify mental health problems and learning disabilities, as “problematic”.

Bradley also noted that special measures for vulnerable victims and witnesses at court were not extended to vulnerable defendants, that there was infrequent use of the Mental Health Treatment Requirement within community sentences and a general lack of information on defendants with poor transfer of information between different stages of the offender pathway.

b. Learning Disability
The Bradley Report highlighted that, although many similar issues affect those with mental health problems and those with learning disabilities, there are distinct differences which must be understood and reflected in the approaches developed to better meet the needs of these individuals.

‘Valuing People Now’: is the first government strategy to discuss offenders with learning disabilities as an independent group. Previous strategies used ‘Mentally Disordered Offenders’ as an all encompassing term and consequently, those with learning disabilities have traditionally been some of the most excluded from policy and service developments. ‘Valuing People Now’ recognises this trend and subsequently emphasises that in service transformation; providers, commissioners and policy makers must focus on those most at risk from exclusion and adapt their approach accordingly.

Guidance released by Department of Health in 2007, highlighted services that support people who offend or are at risk of offending as a crucial component of commissioning. However, in 2009 Her Majesty’s Inspectorate of Prisons (HMIP) found that disability in general is under-recorded in prisons and that no prisons had an identified method for screening for learning disabilities.

Bradley recommended that all CJLD schemes have access to learning disabilities expertise, in addition to introducing a broader programme of training and awareness for all criminal justice staff. The ‘Valuing People Now’ delivery plan set a target to improve coverage by learning disability nurses in criminal justice settings by 2010.

40 Valuing People Now: a new three year strategy for people with learning disabilities, Department of Health, 2009
41 Commissioning Specialist Adult Learning Disability Health Services Good Practice Guidance, Department of Health, 2007
42 Disability Thematic Review, Her Majesties Inspectorate of Prisons, 2009
Both the Bradley Report and ‘Valuing People Now’ identify issues and actions that emerged from No-One Knows, a UK-wide programme run by the Prison Reform Trust that aimed to effect change by exploring and publicising the experience of offenders with learning disabilities and difficulties who come into contact with the Criminal Justice System. No-One Knows examined both learning disabilities, as defined in the Valuing People Now White Paper, and learning difficulties, which include a wider range of impairments such as dyslexia and autistic spectrum disorders.

c. Dual Diagnosis

Dual diagnosis or co-morbidity generally refers to the combination of substance use, misuse, harmful use or addiction, and psychological or psychiatric problems. A ‘substance’ in this context is an illegal or illicit drug, alcohol or prescription drug; while ‘substance misuse’ generally refers to the chronic or complex use of one or more ‘substances’. Diagnosis and treatment is difficult and further complicated by the potential for more than one substance disorder or psychiatric condition to be present at any one time and the possibility for the presence of any existing or subsequent physical illnesses.

One of the drivers for the development of dual diagnosis policy has been the increasing recognition that people who had both mental health and substance misuse problems posed much greater risks to themselves and others than people who had a mental health problem alone. The National Confidential Inquiry Report, Avoidable Deaths in 2006 reported that significant proportions of suicides (27%) and homicides (36%) are committed by those with mental illness and co-morbid substance use. It recommends that provision for dual diagnosis should be central to modern mental health care.

Over the past 15 years there has been a growing awareness of the challenges posed by co-morbidity of mental health and substance use problems resulting in policy guidance aimed at driving the development of services to meet complex needs. Tackling Drugs to Build a Better Britain in 1998 flagged up dual diagnosis as an issue, identifying psychiatric and psychological problems as the most significant health risks for seriously dependent drug misusers. However, the first significant mental health policy guidance to draw attention to dual diagnosis was the National Service Framework for Mental Health in 1999. This highlighted dual diagnosis as a major challenge, recommending that the needs of this group should be met within existing mental health and drug and alcohol services.

In 2001 the Health and Social Care Advisory Service (HASCAS) published their Standards for Dual Diagnosis, and whilst not a policy document, it provided useful guidance. It was not until 2002 that a policy dedicated specifically to dual diagnosis was published: The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. This formed part of a series of implementation guides supporting the National Service Framework for Mental Health.

The guide focussed on the needs of people with serious mental illnesses and substance misuse problems, but it also provided a framework for planning services to meet the needs of the wider range of people who might be considered to have a dual diagnosis. The guide

---

43 No-one Knows: vulnerable defendants in the criminal courts, Prison Reform Trust, 2009
44 National Confidential Inquiry Report, Avoidable Deaths, University of Manchester 2006
45 Tackling Drugs to Build a Better Britain, Home Office, 1998
46 National Service Framework for Mental Health, Department of Health 1999a
47 Standards for Dual Diagnosis, HASCAS, 2001
built on the National Service Framework for Mental Health premise; that the needs of people with a dual diagnosis should be met within existing mental health and drug and alcohol services. It advocated an integrated approach to service provision to enable both mental health and substance misuse problems to be addressed at the same time, in one place, by one team. It acknowledged that specialist or separate dual diagnosis teams were not going to be established on a national basis because of the high prevalence and therefore advocated mainstreaming the care of those with serious mental illness to the mental health services.

The need for mental health and substance misuse services to work more closely together has become a recurring theme in policy guidance which recommends that all local implementation teams should have a strategy in place regarding dual diagnosis, which includes training.

In 2005, a review of the progress in implementing the National Service Framework for Mental Health, dual diagnosis was viewed as ‘the most challenging clinical problem we face’ which required ‘urgent attention’ with a co-ordinated response and better collaboration between agencies.

Although not policy guidance a key driver for mental health trusts is the NHS Litigation Authority Risk Management Standards. Mental health Trusts (Rotherham, Doncaster and South Humber NHS Foundation Trust in North Lincolnshire) are assessed on their ability to demonstrate that they have processes in place to manage the risks associated with dual diagnosis services users. This includes: having arrangement for addressing service users needs, details of internal and external joint working arrangements, the process to be followed where there is a difference of opinion between professionals and the organisation’s expectations regarding staff training as identified in a training needs analysis. Information is also required about which roles or committees have specific responsibility for implementing and monitoring.

Individuals may present during an episode of intoxication or withdrawal; may be dependent on one or more substances; and may suffer from more than one psychiatric symptom or syndrome as a result. It may, therefore, be challenging to distinguish ‘what comes first’ for all of these reasons, and a pre-occupation with ‘what comes first’ often results in potential service users being excluded from help. Service organisation tends to revolve around specific disorders (e.g. mental health, physical health, substance use), which does not take account of the complicated realities of the individuals concerned, even though this feature may, in part, contribute to poor outcomes. Services are likely to have different histories, and differing philosophies and ways of working with people who use those services. Most significantly, they may have little experience of each other’s field.

The nature of the comorbidity may bar some service users from a particular service. For example, the criteria for accessing a mental health service may exclude those who misuse substances and vice versa. Without access to specialist services, people with a dual diagnosis, who may already find it difficult to engage with services, will not only continue to have serious health and social care needs, but are even more likely to be resistant to approaching services in the future.
d. Substance misuse

The Misuse of Drugs Act 1971\(^{49}\) replaced a number of previous Acts and their revisions from the 1960s. It listed controlled drugs in 1 of 3 classes - A, B and C, with Class A drugs considered most harmful. Each Class of drug attracted penalties for a range of unlawful activities including possession, supply and production.

In 2002, as part of the then Labour Government’s 10 year Drugs Strategy, the Drug Interventions Programme (DIP) was introduced. This provides interventions for drug misusing offenders throughout their criminal justice journey: “Across the criminal justice system, drug workers and police identify drug users, with an emphasis on drug testing and intelligence based targeting in police custody suites. They help drug using offenders by challenging their criminal behaviour and brokering access to help with life skills, education and training, employment, drug treatment and housing. The teams share intelligence with local partners who, collectively, take action where drug users don’t want to engage.”\(^{50}\)

During 2002 to 2006, the National Offender Management Service developed a strategy relating to problematic drug users in correctional services\(^{51}\), and the Prison Service developed a number of drug and alcohol strategies\(^{52}\) as well as a good practice guide for alcohol treatment and interventions\(^{53}\). The Probation Service also developed its strategy for working with alcohol misusing offenders during this period\(^{54}\).

The government’s ‘Drug Misuse and Dependence 1999\(^{55}\)” guidelines provided advice for doctors on the clinical management of substance use disorders. The document was updated in 2007 and links closely to NICE guidelines. At the centre of the 1999 guidance was the statement that: “Drug misusers have the same entitlement as other patients to the services provided by the National Health Service. It is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs.”

The guidance emphasised the importance of good assessment in the care of patients with substance use disorders.

In 2006, the National Treatment Agency for Substance Misuse in the NHS published a review of the effectiveness of treatment for alcohol problems\(^{56}\). There was a heavy focus on psychosocial interventions in this review, including brief and extended treatments. Brief interventions were described as effective in a variety of settings, but more research was recommended into their efficacy in the criminal justice system. The review concluded that several lower-intensity treatments had been found to be effective; motivational interviewing, condensed cognitive-behavioural therapy and motivational enhancement therapy, but the data was for specific patient groups in specific settings.

\(^{49}\) Misuse of Drugs Act, HMG Archives, 1971
\(^{50}\) Home Office
\(^{51}\) NOMS, 2005
\(^{52}\) HMPS, 2002, 2003, 2006
\(^{53}\) HMPS, 2004
\(^{54}\) National Probation Service, 2006
\(^{55}\) Drug Misuse and Dependence – UK Guidelines on Clinical Management, Department of Health, 1999
\(^{56}\) National Treatment Agency, 2006
In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy, setting out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause. Again in 2012, the government published its Alcohol Strategy, which set out plans for encouraging a change in drinking behaviour and reducing the harm caused by excessive drinking, to both to individuals’ health and wellbeing and to the wider society.

In 2012, the Sentencing Council issued a definitive guideline for drug offences and the Home Office published a list of controlled drugs, which - it acknowledged - is not comprehensive, but covers those most commonly encountered in the Criminal Justice System.

The government adds drugs to the Misuse of Drugs Act 1971 by making a parliamentary drug control order. The Advisory Council on the Misuse of Drugs (ACMD), was established to determine an individual drug’s harm and to make recommendations on its classification. It can also recommend that chemical compounds related to the drug are classified as well. If a drug is to be controlled permanently, a drug control order is prepared and approved by Parliament; the drug thus becomes a controlled drug - either class A, B or C. The Home Secretary has the power to make a temporary class drug order (TCDO) for an emerging drug that is causing concern. A TCDO can be made within a matter of days and lasts for up to 12 months. This allows the law to change quickly and temporarily, while the ACMD considers the harms further. The UK’s first TCDO on methoxetamine (MXE, a ‘designer’ drug, called “Mexxy” in Home Office releases) came into force in April 2012; it has now been permanently controlled as a Class B drug.

Drugs controlled under the 1971 Act are placed in 1 of 5 schedules to the Misuse of Drugs Regulations 2001 based on:

- an assessment of their medicinal or therapeutic usefulness and the need for legitimate access
- their potential harms when misused

Plans for testing a ‘payment by results’ approach to treatment for drug or alcohol addiction were set out in the 2010 drug strategy,

iii. Women

In recent years, the experience of women in the Criminal Justice System has been an increasing focus for policy makers. In 2007, the Corston Report highlighted the fact that different approaches are required to achieve equal outcomes for men and women. Specifically, the report identified that mental health problems are far more prevalent among women in prison than in the male population or in the general population.

A Report on the Government’s Strategy for Diverting Women Away from Crime was published in December 2009 and highlights achievements that include a 4.2% reduction in the number of women in prison and a 1% increase in community orders. However, a report by the House of Commons Justice Committee in January 2010 expressed disappointment in

58 Controlled Drugs Regulations (Misuse of Drugs Regulations 2001)
59 Reducing Demand, Restricting Supply, Building Recovery Supporting People to Live a Drug Free Life, Home Office, 2010
60 The Corston Report; A review of women with particular vulnerabilities in the criminal justice system, Home Office, 2007
the slow progress in implementing recommendations for vulnerable women offenders, which had been accepted in December 2007\textsuperscript{61}.

Not only does this Report promote the need to progress recommendations for working with women but, as its title suggests, it advocates the adoption of a ‘justice reinvestment’ approach - which channels resources on a geographically-targeted basis to reduce the crimes that bring people into the Criminal Justice System. The report states that:

“The overall system seems to treat prison as a ‘free commodity’...while other interventions, for example by local authorities and health trusts with their obligations to deal with problem communities, families and individuals, are subject to budgetary constraints and may not be available as options for the courts to deploy.”

This view clearly resonates with the experiences of those currently involved in commissioning and delivering CJLD services. Increasingly, the cost and efficiency savings that can be generated within the CJS through early intervention approaches are being recognised and offer a valuable argument to support increasing investment in CJLD provision. The report states that the key priorities for Government policy must be:

- Putting in place appropriate community-based services to prevent potential offenders from entering the Criminal Justice System and to divert them from the offending behaviour which can lead to custody;
- Creating a well-resourced, credible, nationally-available but locally responsive system of community based orders, and
- Committing to a significant reduction of the prison population by 2015 - especially concentrating on women and those whose criminality is driven by mental illness and/or addictions to drugs or alcohol.

The Women’s Justice Taskforce, established by the Prison Reform Trust in 2010, published a report: Reforming Women’s Justice\textsuperscript{62} which looked at the needs of women in the criminal justice system with the aim of maximising the findings of the Fawcett Commission\textsuperscript{63} and the Corston Report. It set out a number of recommendations, including:

- a cross-government strategy to be developed to divert women from crime and reduce the women’s prison population
- reform of the women’s justice system to reflect planned changes to the governance and oversight of youth justice.
- the planned closure of women’s prisons to be accelerated and the money reinvested to support women’s centres and other effective services for women offenders and vulnerable women in the community.
- the new national network of mental health and learning disability diversion schemes in police stations and courts to take account of the particular needs of women.
- professional training for staff in criminal justice agencies including police, probation, Parole Board, judiciary and court services, to include specific material on women’s offending and effective ways to reduce it.

\textsuperscript{62} Reforming Women’s Justice: Final report of the Women’s Justice Taskforce, Prison Reform Trust, 2011
\textsuperscript{63} Women and Justice: Third annual review of the Commission on Women and the Criminal Justice System, Fawcett, 2007
the national Audit office to produce a regular audit of provision for women offenders and its effectiveness

In March 2013, the government published its Strategic Objectives for female offenders\(^{64}\), which describes the four Key Priorities to be taken forward within the Government’s agenda for transforming the rehabilitation of offenders:

1. Enhanced provision in the community for female offenders:
2. Transforming rehabilitation for female offenders:
3. Review of women’s prison estate:
4. Whole system approach

The six-page strategy contains a foreword by Helen Grant: Under-Secretary of State for Justice and Under-Secretary for Women and Equalities. She heads up a new ministerial team within the Ministry of Justice, which has started work on reforming the rehabilitation of offenders and addressing the failings in the youth custodial estate to break the cycle of reoffending. It is intended that she will chair a new Advisory Board for female offenders. The Board will provide expert advice, working across Government and with key stakeholders on the Key Priorities - an echo back to Corston’s recommendation to form an Interdepartmental Ministerial Group.

iv. Black and Minority Ethnic (BME) Groups
In Ethnicity and Health (2007)\(^{65}\), it is acknowledged that people from Black and Minority Ethnic (BME) backgrounds generally suffer from poorer health than the overall population in the UK; “some BME groups fare much worse than others, and patterns vary from one health condition to the next.”

The main factor is reported to be the poorer socio-economic status of BME populations, but there are a number of other factors involved including biological susceptibility - eg sickle cell anaemia, the long-term impact of migration, stress and anxiety caused by racism and discrimination, poor delivery and take-up of health care and differences in culture and lifestyles.

Whilst policies and plans have increasingly aimed to tackle health inequalities, ethnicity has not consistently focussed within them.

Ethnicity and Health refers to data based on treatment rates, which show that BME people are much more likely to be diagnosed with a mental illness than the White population, with Black Caribbean people up to seven times more likely to be given a diagnosis of psychosis than White British people.

“There is evidence of ethnic differences in risk factors that operate before a patient comes into contact with the health services, such as discrimination, social exclusion and urban living. There is also evidence of differences in treatment. For example, Black Caribbean and African people are more likely to enter psychiatric care through the criminal justice system than through contact with the health services. Some researchers suggest that psychiatrists diagnose potential symptoms of mental illness differently depending on the ethnicity of the patient”.

---

\(^{64}\) Strategic objectives for female offenders, Ministry of Justice, March 2013

The relationship between ethnicity and crime has been the subject of a wide range of study and comment. Under the Criminal Justice Act 1991\(^6\), section 95, the government publishes annual statistics based on ethnicity and crime (see table below).

Proportion of individuals at different stages of the CJS process by ethnic group compared to general population, England and Wales:

<table>
<thead>
<tr>
<th>Stage</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Mixed</th>
<th>Chinese or Other</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged 10 or over (2009)</td>
<td>88.6%</td>
<td>2.7%</td>
<td>5.6%</td>
<td>1.4%</td>
<td>1.6%</td>
<td>-</td>
<td>48,417,349</td>
</tr>
<tr>
<td>Stop and Searches (s1) 2009/10</td>
<td>67.2%</td>
<td>14.6%</td>
<td>9.6%</td>
<td>3.0%</td>
<td>1.2%</td>
<td>4.4%</td>
<td>1,141,839</td>
</tr>
<tr>
<td>Arrests 2009/10</td>
<td>79.6%</td>
<td>8.0%</td>
<td>5.6%</td>
<td>2.9%</td>
<td>1.5%</td>
<td>2.4%</td>
<td>1,386,030</td>
</tr>
<tr>
<td>Cautions 2010*</td>
<td>83.1%</td>
<td>7.1%</td>
<td>5.2%</td>
<td>-</td>
<td>1.8%</td>
<td>2.8%</td>
<td>230,109</td>
</tr>
<tr>
<td>Court order supervisions 2010</td>
<td>81.8%</td>
<td>6.0%</td>
<td>4.9%</td>
<td>2.8%</td>
<td>1.3%</td>
<td>3.2%</td>
<td>161,687</td>
</tr>
<tr>
<td>Prison population (including foreign nationals) 2010</td>
<td>72.0%</td>
<td>13.7%</td>
<td>7.1%</td>
<td>3.5%</td>
<td>1.4%</td>
<td>2.2%</td>
<td>85,002</td>
</tr>
</tbody>
</table>

Note: * Data based on ethnic appearance and therefore do not include the Mixed category.  
Source: Statistics on Race and the Criminal Justice System 2010; Ministry of Justice October 2011.

The statistics highlight differences in rates and types of contact between different ethnic groups and the CJS and a range of explanations have been attributed to these differences over time. In the early part of the 19th century, opinions were particularly influenced by the work of Charles Darwin; focusing on the perceived biological and psychological characters of offenders.

Other commentators have suggested the underachievement of black males (particularly of Caribbean descent) in school and the lack of positive role models as contributory factors. Others have cited the predominance of images and music perceived as encouraging the criminal behaviour of young black males.

Young people of all ethnic groups are more likely to commit crime. The black population of the UK is significantly younger than the general population (see table below).

Population by ethnic group: England, 2001 Census

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Mixed</th>
<th>Chinese or Other</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>44,679</td>
<td>1,132</td>
<td>2,249</td>
<td>642</td>
<td>436</td>
<td>49,139</td>
</tr>
<tr>
<td>% of total</td>
<td>90.92</td>
<td>0.77</td>
<td>1.15</td>
<td>0.35</td>
<td>0.4</td>
<td>100</td>
</tr>
<tr>
<td>Median Age</td>
<td>41</td>
<td>28</td>
<td>26</td>
<td>16.5</td>
<td>0.4</td>
<td>37</td>
</tr>
</tbody>
</table>

Source: 2001 Census, Tables KS06, C0533

The director of the Centre for Crime and Justice Studies, Richard Garside, has criticised the tendency to focus on race, when the difference in male and female crime rates, is far greater than that between racial groups. The Home Office has also published a study showing that, once other variables had been accounted for, ethnicity was not a significant predictor of offending, anti-social behaviour or drug abuse amongst young people.

---

4. Findings:

4.1. Pre-Arrest and Police Custody

Literature Review

Key documents reviewed:

- **(OHRN)** Offender Health: Scoping Review and Research Priorities within the UK - July 2009 (OHSR 2009) Report for Offender Health at the Department of Health: Charlotte Lennox, Dr Jane Senior and Professor Jenny Shaw - Offender Health Research Network (OHRN); University of Manchester - Scoping review of literature surrounding the health of people in contact with police custody, court and probation service prior to 2009.
- **(Bradley)** Bradley Report - Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system, April 2009
- **(CJLAS)** Criminal Justice Liaison and Advice Service - Effective Intervention throughout the Criminal Justice Process for Offenders with Learning Disabilities and/or Mental Health issues - Andrew Stimpson, Yorkshire and Humber Improvement Partnership (YHIP) - Offender Health and Social Care, 2013
- **(WYP)** West Yorkshire Police Custody Health Needs Assessment, Toni Williams, Clare Humphreys, Jason Horsley for West Yorkshire Police, 2012

Introduction

The Police are often a person’s first contact with the Criminal Justice System, although the police themselves admitted that they had little knowledge of the health needs, or had the means/expertise accurately to assess those needs, of people in their custody. Nonetheless, it is believed that many people who are brought into custody have chronic or acute health care needs and yet are amongst the least likely in our society to be accessing healthcare services voluntarily. *(DH 2007)*

Lord Justice Bradley also highlighted this crucial role the Police have in being the initial contact between the prisoner and the Criminal Justice System. It should, he suggested, provide an early opportunity through police intervention and liaison to engage the relevant services to initiate change and avoid future problems connected with the health needs of prisoner. Be that as it may, Bradley was surprised to find that the police stage was, in fact, the least developed in the offender pathway in terms of engagement with health and social services, with intervention not occurring until further along in the legal process, at court and sentence stages. *(Bradley, pg 34)*

Early intervention and Neighbourhood Policing

Bradley notes that Police intervention and liaison provide an opportunity to improve access to services for offenders and potential offenders, in addition to improving safety for individuals and the public. Furthermore, this intervention and liaison supports the police in fulfilling their responsibilities, besides providing valuable information to agencies within the criminal justice system.

The Neighbourhood Policing model enables the police to work proactively in local communities with local agencies to help to identify people with mental health problems, in particular those at risk of offending or re-offending. Bradley identifies Safer
Neighbourhood Teams as the ideal forum for looking at mental health and learning disability issues, and the early identification of people at risk of offending, particularly utilising the role of the PCSO as the ‘eyes and ears’ of the police in local areas. (pg 34). Bradley identified examples of good practice but concluded that ‘there are pockets of good work under way, but this has yet to be consistently introduced across England and Wales.’ (pg 37) and made the following recommendations:

- Local Safer Neighbourhood Teams should play a key role in identifying and supporting people in the community with mental health problems or learning disabilities who may be involved in low-level offending or anti-social behaviour by establishing local contacts and partnerships and developing referral pathways.

- Community support officers and police officers should link with local mental health services to develop joint training packages in order to share mental health awareness and learning disability issues.

Opportunities for diversion prior to arrest
In the event of a petty crime involving a person who appears to have a mental health problem, the crime may be recorded but no further criminal justice action taken. The police should, however, sign-post to/ liaise with appropriate local health and social care services where a mental health or learning disability problem has been identified. (Bradley, pg 36)

Cheshire Constabulary follows a procedure whereby, if a petty offence has been committed but mental health problems seem apparent, officers prioritise the care and treatment of the individual over the criminal behaviour. The officer can invite the person with mental health problems to the police station at a later date for a formal interview in the presence of an Appropriate Adult. If an offence is admitted and a caution is appropriate, the caution is issued. Otherwise, a report is sent to the Crown Prosecution Service (CPS) for their consideration.

Penalty Notices and Anti-Social Behaviour Orders
The majority of Penalty Notices for Disorder (PNDs) and Anti-Social Behaviour Orders (ASBOs) are used to tackle behaviours that can also be indicative of mental health crises. Participants in the review told Bradley that neighbourhood policing teams were encouraged to use ASBOs and PNDs. These do, however, have the possibility of producing an unwonted and inappropriate outcome in cases of non-compliance - i.e. accelerating vulnerable people into the criminal justice system rather than towards the appropriate services.

Police Custody and PACE
Police and Criminal Evidence Act (PACE) and Codes of Practice place a duty on the Custody Officer with regard to detainees, with an obligation placed on her/him to identify potentially vulnerable people and to determine when to contact an appropriate healthcare professional. The Custody Officer is not allowed to let a detainee be interviewed if s/he thinks it would damage the detainee’s mental state. The Custody Officer must evaluate the potential risks of custody by asking a series of questions, and can call in a health care professional for additional help to ascertain potential risks when making decisions about a person’s continued detention. (ACPO, 200668)

PACE requires the police to provide clinical attention to those presenting with physical and mental health needs. If a detainee requires medical attention it is the responsibility of the Custody Officer to ensure that healthcare professionals have all the available information relevant to the detainee’s treatment. Custody Officers are also expected to refer to the Police National Computer (the PNC) as a source of risk-pertinent information. However, although ‘health problems’ is not a prescribed field on the PNC, there is a facility to add ‘markers’ - but this system and its benefits are limited in this regard, as its primary focus is risk as opposed to the needs of the detainee (OHRN - pg11).

Where the Custody Officer and the custody nurse have identified mental health need, a Forensic Medical Examiner (FME) may be asked by police to undertake further assessment. FME attendance may instigate an immediate assessment under the Mental Health Act and, where appropriate, the individual can be diverted out of the criminal justice system into a psychiatric setting.

Health of Detainees in Police Custody
In the light of the raft of published literature reviewed by the OHRN study of 2009, one of the priorities identified was for up-to-date research on prevalence of mental illness, learning disability, physical health and drug and alcohol use of detainees in police custody. Furthermore, it has been identified that as the population of people detained in police custody is dynamic, there is a need for continuous research in order to inform training and service provision. One example cited was how the changes in the types of drugs detainees use (moving from opiates to stimulant use, for example) which, in turn, not only impacts on the care and treatment required in police custody, but has consequent implications for updating the training needs of police officers, custody nurses and FMEs.

Physical health problems
West Yorkshire’s review of the published literature found that a range of acute and long term physical health problems were reported by detained persons, conditions which may be exacerbated in the absence of appropriate healthcare, as well as those that present a health and safety risks to others. Payne-James et al (2008) reported a range of potentially complex conditions amongst detainees including: asthma, epilepsy, diabetes, deep vein thrombosis, pulmonary embolism, hypertension, gastrointestinal disorders, hepatitis and musculoskeletal problems. The most commonly reported physical health problem was asthma, with 10% of detainees reporting experiencing asthma, followed by epilepsy (5%) and gastrointestinal disorders (5%).

McKinnon and Grubin (2010) found a similar range of physical health problems amongst detained persons with injuries: epilepsy and asthma being the most commonly documented conditions. In an Amsterdam-based study (Celeen, et al, 2012), 52.5% of detainees reported at least one physical health problem. Amongst males, diabetes, asthma, HIV, epilepsy, lacerations, pain and musculoskeletal problems were the most commonly reported health problems. Amongst female detainees, hypertension, diabetes, asthma, HIV, musculoskeletal problems and pregnancy-related issues were commonly reported.

Alcohol
Latest available data suggests that 9.3% of men and 3.6% of women in England drink at a level described as ‘dependent’ (Office of National Statistics, 2007). Amongst those detained in police custody this proportion appears to be significantly higher. The Arrestee
Survey conducted in 2005/06\textsuperscript{69} estimated that 57% of detainees in police custody were dependent drinkers, with men more likely to be dependent drinkers than women (57% of men compared with 50% of women). Patterns of alcohol use also varied by age with younger men and women more likely to be dependent drinkers than older detainees. However, Payne-James, et al (2010) reported a much lower prevalence of alcohol dependency, with 25% of detainees drinking at a level considered dependent, whilst an earlier study by Payne-James et al (2005) reported an even lower prevalence of 15%.

Best, et al (2002) found that detainees under the influence of alcohol are a major problem for the police. This study explored the possibility of FMEs delivering brief alcohol interventions in custody suites. Awareness of brief intervention was low and most of the FMEs interviewed said they had never delivered a brief intervention either in their general practice or in the custody suite and questioned if it was within their remit.

Robertson et al (1995) carried out observations of detainees at seven police stations in London over a three week period noting the number of people arrested for offences of drunkenness and the apparent degree of drunkenness of all detainees, irrespective of arrest offence. In this study, only 5% of those arrested for drunkenness alone were charged - however, the authors stated that despite this the police must continue to arrest and detain the drunk and incapable in the absence of other suitable alternatives. The report also noted that in contrast with other mentally-disordered offenders, diversion of the chronic drunken offender from the CJS has not resulted in diversion to health care.

\textbf{Substance misuse}

Bennet and Holloway (2004) reported on the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) programme: a national research study of interview and voluntary urine tests designed to establish the prevalence of drug use amongst arrestees. Testing took place across 16 sites in England and Wales over three years around the clock with 3,091 arrestees taking part. Urine tests found that 69% of arrestees tested positive for one or more illegal drugs and 36% for two or more such substances. Most common were: cannabis 48%, opiates 31%, alcohol 23%, cocaine 22%, benzodiazepines 13% amphetamines 7% and methadone 6%.

Payne-James, et al (2005) gave a structured questionnaire to self-admitted illicit drug users, 113 detainees consenting to take part. Thirty per cent were dependent on heroin or crack, significant mental health problems were reported in 18% of the sample and alcohol dependence in 15%. Mean length of drug use was 7.5 years, and 82% had served a previous prison sentence and 54% used drugs in prison. In terms of previous interventions 38% been on a rehabilitation programme, 11% DTTTO, 32% Arrest Referral schemes and 10% were in contact with community drug teams at time of assessment.

Stark, et al (2002) stated that one of the major problems of assessment in custody was confirming the history of recent drug-taking given by the detainee. This study collected histories of 222 detainees. The analysis of urine samples found that where the person claimed daily use of methadone it was absent from the urine screening in 25% of cases.

\textbf{Learning Disability (LD)}

The reported prevalence of LD in police stations varies from 0.5% to 9% of all detainees across published research (OHRN). Bradley cited the lack of accurate data about the numbers of people arrested and taken into police custody who have learning disabilities as due to the inadequacy of identification, difficulty in diagnosis and lack of consistent data collection.

Scott, et al (2006) looked at prevalence and mental health needs of people with LD detained in police custody: a Community Mental Health Nurse (CMHN) screened custody record forms for evidence of mental health problems or learning disability in an inner-city, inter-agency police liaison service over a 3 year period. Almost 1 in 10 were judged to have possible or definite LD; 63% had a history of causing harm to others; 56% a history of self-harm; 56% had consumed harmful levels of alcohol and 27% abused drugs. Researchers concluded that there were a sizeable number of offenders with LD who often had complex mental health needs which were not currently being met.

Loucks (2008) carried out a review of previous literature which attempted to investigate the prevalence of LD in the CJS. The report suggested 20-30% of offenders have learning difficulties or disabilities that interfere with their ability to cope with the CJS. It did, however, note that the ways in which LD were defined and assessed varied widely – i.e. there was no standardised procedure. Moreover, as there was no routine assessment process, people were unlikely to be identified unless their behaviour gave cause for concern.

In respect of the above, more recent recommendations from ‘Effective Intervention throughout the Criminal Justice Process for Offenders with Learning Disabilities and/or Mental Health Issues’ includes the need for a Learning Disability Screening Questionnaire to be piloted in police custody, and for Mental Health and Learning Disability Awareness training to be prioritised as mandatory for all involved agencies.

**Mental Health**

Prevalence rates of mental illness in detainees in police custody vary widely. Robertson, et al (1996) concluded that identifying those suffering from mental disorder present major difficulties for the police and that although evidence suggests that identification is more accurate in the most severe cases, there are particular concerns that problems such as depression and anxiety and less serious mental illness are missed.

Bradley was unable to obtain a clear breakdown of the number of people arrested with mental health problems due in part to the difficulties identifying those who have mental health or learning disability needs. This is exacerbated by the high numbers of detainees reported to be ‘drunk’ on arrival at police stations and the common use of drugs which can mask mental health issues.

In 2006 Revolving Doors Agency explored ways to identify and address mental health problems at the earliest opportunity for those in contact with criminal justice agencies by mapping current opportunities so that the multiple needs of offenders can be spotted. The final report focussed on healthcare in police custody and found:

- Assessments generally conducted in open custody suites - little privacy or confidentiality
- Assessments varied across forces - no standard definition of terms
- Police training developed and delivered locally - no national standards to measure service or performance
- Many detainees have dual diagnosis making it hard for untrained custody staff to accurately identify need
- Custody officers have few avenues to seek further support/guidance on health issues.

---

Bradley found widespread concern among stakeholders about the current assessment of detainees in particular that the erroneous perception is that custody is ‘a safe place’ leads to delays in engagement with health professionals for assessment. Bradley’s findings reflect those of the Revolving Door Agency and additionally highlighted the reliance on self-reporting in the custody suite environment which does not encourage disclosure of mental health problems for fear of stigma and discrimination. Furthermore, it suggests that previous negative experiences with the police may also contribute to a reticence to disclose information.

In the BDP report, senior police officers and mental health leads from all forces expressed concern that: “people with mental health problems or learning disabilities who were unwilling to self-report or who were not displaying very clear signs of mental distress were being missed.” Identifying mild learning disabilities and conditions on the autistic spectrum were reported to be particularly difficult to identify. Police officers interviewed were keen to emphasise that their “primary purpose in screening is to ensure that arrestees are held safely in custody and their rights are maintained; not to facilitate access into treatment.” (p13)

**Use of an Appropriate Adult**

Home Office 2006 states that if a detainee is considered to have mental health difficulties or be mentally vulnerable, then an Appropriate Adult (AA) should always be contacted. The role of an AA was created by PACE to safeguard the rights of vulnerable adults (and young people); the guidelines state that AAs should be experienced in dealing with MH problems and should not just be a passive observer - their responsibilities include: advising the detainee, facilitating communication and observing the conduct of any interviews.

Gendle and Woodhams (2005) interviewed eight police sergeants from Humberside Police about their perceptions and knowledge of people with learning disabilities. Many officers felt the Appropriate Adult was not always appropriate: sometimes they were a family member and felt to be not trustworthy and of limited assistance. Officers were concerned about ‘getting it right’ and wanted to achieve best justice for people with LD and noted that on occasions the police cells were not the right environment with concerns about LD detainees’ comprehension of cautioning and questioning. The biggest problem cited was confusion between identifying mental health problems as distinct from LD. The report concluded that the police officers were keen to ensure that people with learning disabilities entering the police station received the support they need, however they highlighted variability in training and the need for proactive networking.

Nemitz and Bean (2001) analysed over 21,000 custody records in four police stations in cities in the East Midlands area of England, and found the Appropriate Adult was used in only 38 instances (or 0.016%). Based on the lowest or most conservative extract of the numbers of mental illness in the population, there should have been about 400 (1.9%), and on the more generous estimate, about 3,000 (14%).

Bradley found there were difficulties in getting timely access to the AA service and questioned if detainees were inclined to forgo the service if it meant spending a longer time in custody. He found concerns about the quality of AA service and a lack of consistency in the role, and called for a review of the role of Appropriate Adults in police stations with the aim of improving the consistency, availability and expertise of this role. He also called for Appropriate Adults to receive training to equip them to give the most effective support for individuals with mental health problems or learning disabilities.
The 2007 review conducted by the Prison Reform Trust also found that access to an AA was patchy, as suspects' needs were often not identified and there was a lack of individuals who could effectively undertake the role. This review found:

- Inconsistent decision-making on enforcement, diversion and disposal options;
- Limited referral for clinical attention in areas, and inconsistencies in the attention received from healthcare professionals;
- Criteria for assessing fitness for interview lacked clarity;
- Presentation and follow-through of suspects’ rights to legal advice is sometimes poor.

The BDP report found that Police experienced problems in obtaining an ‘appropriate adult’ within acceptable timescales and this is mirrored in Inspectorate reports on custody provision across the region where “significant delays, difficulties with out-of-hours provision and refusals by the EDT to attend” were found. Service-users also reported that interviews were conducted without the presence of an ‘appropriate adult’. There was a concern expressed that “medical professionals in custody suites act as gatekeepers to such support using their own higher thresholds for access to services rather than the lower threshold outlined in PACE legislation.”. (p13)

**Section 136 of the Mental Health Act**
The police have powers under Section 136 of the Mental Health Act 1983 to remove from a public place to a place of safety a person who appears to be suffering from a mental disorder and is immediate need of care or control. A ‘place of safety’ can be a psychiatric unit, or a police station, or a hospital accident and emergency department. Police custody is widely viewed as not being a suitable environment for people with mental disorder as it is implicitly criminalising people for what is essentially a health need.

Docking et al (2008), carried out a review of police custody as ‘a place of safety’ on behalf of the Independent Police Complaints Commission (IPCC) and found large variations across police forces in the use of police custody for this purpose. Just under two-thirds of detainees were male - comprising 78% of white ethnicity, 4% black, 3% Asians, 1% Chinese or other ethnic group, 1% mixed ethnicity and 14% were unknown/not stated. When compared to local population data they found black people were almost twice as likely as white people to be detained. Researchers estimated that 11,500 people were detained under Section 136 in 2005/06, with the average length of time spent in custody being 10 hours. Additionally, 41 of the 43 constabularies confirmed their continued use of a police station as a place of safety.

Guidance from the Department of Health made changes to the use of Section 136, under Section 44 of the new Mental Health Act 2007, allowing a person to be taken from one place of safety to one or more different places of safety, with police stations only to be used in exceptional circumstances. ACPO has suggested that police forces must develop and agree protocols with mental health trusts and primary care trusts to identify a first-choice place of safety, and the criteria for use.

In his 2009 report, Bradley called for all agencies involved in the use of Section 136 to develop joint protocols on the use of these sections and wanted to see immediate discussions to identify suitable local mental health facilities as the designated place of safety to ensure that the police station is no longer used for this purpose.

---

Despite this, the Revolving Door Big Diversion Project (BDP) report of 2012 states “analysis suggests that Section 136 of the Mental Health Act is being used inappropriately when an alternative, less restrictive intervention might be offered instead.” (p11)

During the period September 2010 - August 2011, 60% of s136 detainees were detained in police custody in Cleveland; just over half of such detentions were in police custody in Northumbria and 30% in Durham in 2011 and yet 76% of s136 detainees in Cleveland and 55% in Durham were released with no further action being taken.

The BDP report outlined that multi-agency policies in the region give clear time limits within which an assessment by a Section 12 doctor and an Approved Mental Health Professional (AMHP) should take place. Be that as it may, those interviewed reported that waiting times were often longer than prescribed - especially during out of hours and service-users said that this added to their distress. Police officers were particularly concerned that a long wait with a detainee in the mental health unit was a “significant use of police resources”. Reasons given for these delays included a lack of “designated staffing to cover the s.136 suites and particular difficulties securing the attendance of an AMHP.” Restructuring had reduced the size and capacity of Emergency Duty Teams (EDTs) and this caused problems, particularly out of hours.

The BDP report finds that effective joint working between Mental Health Crisis teams and the police is crucial. One playing an important role in supporting those with “severe mental health problems in the community”, whilst the police often have to handle “crisis situations in the community where there is a risk of harm to the public”. In addition; that this is not limited to practice around s136 but also includes “a range of other situations in which cooperation is needed to manage a patient with deteriorating mental health needs”. Current arrangements for joint working were found to be not always as effective as needed. There was a perception from police officers interviewed of: “A lack of cooperation from mental health teams and a reliance on police officers to provide support that was perceived as out of their remit”.

Meeting the health needs of detainees in Police Custody
In the past, police forces commissioned healthcare provision for persons detained in police custody. This is now carried out through NHS commissioning structures. In 2011, West Yorkshire Police elected to become an early adopter to work in partnership with NHS commissioners to scope out transferring police detainee healthcare commissioning to the NHS Commissioning Board, and carried out a health needs assessment to support the process.

The West Yorkshire Police Custody Health Needs Assessment found that detainees had a wide range of complex and/or long-term conditions and health problems. The police and custody healthcare provider clearly have a role in the acute management of health problems of detainees, however their role in the long-term management was, however, less well defined. (WYP pg 8).

Access to accurate and timely information on the health of detainees was highlighted by many stakeholders as an area of concern. The absence of electronic healthcare records in custody suites and lack of access to primary care records were both identified as problematic because healthcare professionals in police custody suites often struggle to verify self-reported information around issues such as medication use, past medical history and health problems identified from previous custody episodes.

Stakeholders participating in the OHRN study raised the issue of ‘in-possession medication’, highlighting the confusion among custody staff over prisoners having access to medication and also around custody officers giving out medication. There were also
concerns expressed about the quality of and lack of a standardised level of care from providers of healthcare in police custody. In addition, the police did not know to whom they should make onward health-related referrals and, furthermore, they were unsure what they could do with any health information they obtained and confidentiality. There were also concerns about specific populations within police custody, such as the under 18s and pregnant women, and offenders ‘in crisis’ where detainees were ‘ill’ -- but not ill enough to warrant sectioning, particularly, in the context of people detained under Section 136.

The BDP also identified the need for clear care pathways with Police from two of the three forces in the North East region reporting that pathways into care were confusing and that there needed to be a clearer structure for referral and assistance. Those police at the frontline called for a single point of contact with mental health services. Gaps in pathways for learning disability were reported and it was felt that more could be done by community learning disability (LD) services to promote their service to the police and to strengthen care pathways. Across the region, care pathways appeared clearer for support with drug issues as there was specific drug-arrest referral provision in all police custody suites, but there was, in contrast, evidence of gaps in alcohol-custody provision.

Listening to Young Women in Police Custody: Mental health needs and the police response (Matina Marougka and Rachel Cass, 2012); a research project carried out in 2011/12 in London engaged with 24 young women (aged 16-25) to look at how their mental health needs were met in police custody. Some participants reported that they had not been asked any questions about their physical, mental or emotional health needs whilst in police custody and there existed inconsistencies in the way in which re-offenders had their needs assessed. Some women who had been in police custody on more than one occasion said they had not been asked the same questions by custody officers each time, so their needs went undetected on occasions. The need for cultural and religious sensitivity when exploring mental health issues amongst young women in police custody emerged with issues such as the removal of headscarves from Muslim young women and the discussion of sexual health issues in front of male family members being highlighted.

**Intervention and Diversion from police custody**

Bradley identified a clear need to explore further the potential for placing responsibility for clearer identification and assessment of mental health problems or learning disabilities at an early stage of the offender pathway. To this end, he commissioned Tribal Consultants to carry out a cost/benefit analysis of interventions at different stages of the criminal justice system. The first of these interventions required the screening and assessment process at the police stage. The Tribal report found that triage and assessment processes at police stations, could save up to 4,493 remand days, equating to 12 full time prison places and (based on an annual cost of £23,585 per prison place) nearly £300,000 in annual savings (2008).

Bradley called for all police custody suites to provide:

- Access to liaison and diversion services to improve screening and identification of individuals with mental health problems or learning disabilities;
- Information to police and prosecutors to facilitate the earliest possible diversion of offenders with mental disorders from the criminal justice system; and,
- Sign-posting to local health and social care services as appropriate.
Stakeholder Interviews

Pre-arrest/Early Intervention

A range of agencies in North Lincolnshire regularly come into contact with offenders or people at risk of offending out in the community. Joint working between Humberside Police, Safer Neighbourhoods and North Lincolnshire Homes at a neighbourhood level has brought about some very positive outcomes for residents. The Vulnerable Adult referral process has the potential to identify vulnerable offenders or those at risk of offending with health and wellbeing needs. There is an agreed protocol in North Lincolnshire for when a vulnerable adult referral is made, this is not a statutory requirement but it is best practice.

Fiona Pilkington was a mother who killed herself and her disabled daughter after suffering years of harassment from a local gang in Leicestershire which led to a review of safeguarding adult’s policies to protect vulnerable victims of antisocial behaviour. Agencies in North Lincolnshire have developed an assessment tool to be used in the community to assess a vulnerable person’s risk factors and make appropriate safeguarding referrals.

However, there were examples provided where agencies felt that the protocol was not being effectively implemented. A Housing Officer reported having had concerns about a female tenant with a young son who was being abused by her neighbours; she was in very low mood and had threatened to kill herself and her son. The housing officer used the assessment tool and gave the case a score which called for immediate action to safeguard the individual and made the appropriate referrals. However, the officer did not feel the response from other agencies was adequate and that as he considered the family to still be at risk called a multi-agency meeting which key agencies did not attend.

There were also concerns raised around support for staff working with clients who have not committed an offence but are threatening to. Rotherham, Doncaster and South Humber Mental Health Service (RDASH) gave anecdotal evidence of a personality disordered service user with no history of offending who had threatened and planned to kill people. The Care Coordinator felt that s/he had been left to manage the risk and as the client had not yet committed a crime there was little s/he could do other than to inform the intended victim.

Humberside Police are currently training officers who are the first response to reports of incidence such as a domestic dispute where alcohol is present and no arrest required that they ask if those involved in the incident to provide them with signposting to alcohol services to self-refer. The Police and Community Alcohol Services are linking together to respond to street drinking and the police powers under Section 27 (Direction to Leave) of the Violent Crime Reduction Act, and alcohol banning orders. With consent the Police will refer anyone who has been subject to any sanction to the Alcohol service who writes to them to offer treatment or support related to their alcohol use.

Police Custody

In March 2013, 264 people were detained in Police custody at Scunthorpe Police Station. Of those 112 were alcohol related offences and 17 also presented with substance misuse issues and 16 reported mental health issues. Between January and March 79 people (61 male and 18 female) were drug tested on arrest in police custody.

When a detainee is brought into Police Custody the Police must determine if the individual is fit to be detained and interviewed and to ensure full compliance with the Human Rights Act and PACE. An extensive risk assessment is carried out which follows a set
standardized format which covering physical injuries, health needs, medications, substance use and mental health. Detainees are asked if they need help with reading and writing and where they indicate that they do the information they are required to receive in accordance with PACE is read out to them and they mark to confirm this with an ‘x’.

There are occasions where a detainee does not disclose any health conditions which may impact on their risk and fitness to be interviewed or detained. A detainee with substance misuse issues may not disclose accurately when asked about their recent drug and or alcohol consumption knowing that this may delay their time in custody when they just want to get out. Therefore as an initial assessment upon entry into custody all detainees are continually monitored a medical assessment sought if there are any concerns.

Currently the health needs identified in custody records are not captured in monitoring reports so it is not possible to obtain an accurate picture of the extent of and type of health needs presented by detainees in police custody in North Lincolnshire.

**Healthcare provision in Police Custody**

Medacs Healthcare is the forensic medical services provider for Humberside Police providing custody suite healthcare management. There is one healthcare worker based in the custody suite during office hours and FME doctors are on call. Where a health professional is required for a forensic seizure, to do a medical, drugs test or administer medicines Medacs are contacted. The Police report good response times to these requests from Medacs.

Detention officers, who are Police employees, will administer some medication where authorised by the Doctor and recorded on the custody sheet and the Police will collect prescribed medication from a detainee’s home or collect their prescription again only when directed to do so by the FME.

Substance Misuse agencies expressed concerns that the Methadone is no longer administered in the cells. They reported that in the past procedures whereby if a detainee was in treatment with an agency and wished to have their prescribed Methadone this could be safely and legitimately administered by FMO’s (Forensic Medical Officers), This no longer occurs. Stakeholders - though fully appreciative of the risks for the Police as they do not know what drugs the detainee may have taken before they were arrested - felt the decision had been made without consultation and consideration of the impact on the detainee’s health and that there were issues of equity. One consequence has been that where a person is detained over the weekend and then released their tolerance to the methadone will have changed so they then have to see a prescriber, be reassessed, and the dose re-introduced in a safe manner.

The Police report that the risks of detention for a chronic alcohol can be much higher than that of a drug user, and provided anecdotal evidence of the FME prescribing 4 cans of Guinness for a chronic alcoholic to keep them alive.

Where a detainee is considered to receive hospital treatment they are escorted to A&E by two police officers. The Police report difficulties liaising with A&E staff and concern that often detainees are discharged from A&E without a Care Plan so Police Custody staff do not know what their needs are or risk they present when they are back in the cells. This can be particularly problematic with people who secrete items in their body orifices. Police observed that the quality of the Care Plan (when provided) varied a great deal and called for the development of a protocol between themselves and the A&E department to resolve these issues in the best interests of the patient/detainee.
North Lincolnshire Drug Intervention Programme (DIP) provides a range of services to people over the age of 18 affected by drug use and involved with the criminal justice system. The aim of the programme is to get drug misusing offenders out of crime into and staying in treatment to reduce reoffending. The Arrest Referral Team engage with drug users in police custody, accessing offenders at arrest and offering them fast track assessment and referrals into prescribing and treatment.

Where drug consumption is evident or suspected detainees are drug tested by Detention Officers, and if they test positive for a Class A drug they are assessed by a DIP worker. The detainee will be advised on harm minimisation and safer practice including consumption and method of use. At this initial assessment health needs are not explored in detail this is carried out after release via an in-depth health screening would be conducted by an on-site nurse at the DIP offices.

When a person has been arrested for any number of trigger offences they are also drug tested and if positive will be placed onto the Restriction on Bail Scheme and released on bail to report to Shelford House for a drug assessment; where the Probation Service will assess their suitability for a Drug Rehabilitation Requirement Order outcome at Court.

When a detainee is released from custody either unconditionally or on bail to report back to the police station, court or Shelford House the Police carry out a pre-release risk assessment. When a detainee is remanded in custody for appearance in court they are accompanied by a Prison Escort Record (PER1). This does not provide in-depth information about health needs’ it relates predominately to risk to the detainee or court staff such as HIV, if they are a ‘spitter’ or have history of secreting weapons.

**Learning Disability**

Recently with the aim of improving the identification of detainees with a Learning Disability a pilot was launched at Scunthorpe police custody suite whereby anyone testing positively for drugs in police custody would receive LD screening by the DIP worker as part of their assessment. Where evidence of LD is presented they are then referred - with their consent to the LD Team - based at the Ironstone Centre.

The custody sergeant as enshrined in PACE must ensure a mentally disordered detainee is provided with an Appropriate Adult, this can be a relative of friend or the Appropriate Adult Service commissioned by North Lincolnshire Council Adult Services and provided by Voiceability. The Police reported concerns about the availability of the AA service outside of office hours as this can lead to vulnerable adults spending longer in custody waiting for an AA which is not equitable.

Data from the Appropriate Adult Service for January to March 2013 shows a total of 27 referrals (23 male, 4 female) were received for an AA with an average response time between one to two hours.

There is no formal diversion from custody scheme in place for detainees with learning disabilities, so options for disposal are limited. There was a view expressed that sometimes the police expect Adult Services to take custody of mentally disordered detainees as they do not know what else to do with them.

“We need to work more closely with the police and the custody sergeants because their assumptions are sometimes way off beam - it has got better but did used to get ‘we don’t know what to do with them come and pick them up and put them into care’. Doesn’t happen so much now but you can get put under a lot of...”
pressure by the police in the custody suite wanting you to move them off because his perception is that he is not a bad boy naturally”.

Mental Health
In accordance with PACE the Police will arrange to have a mental health professional carried out an assessment to determine if a person is fit to be detained and to be interviewed when required. This would involve the RDASH Crisis Team and it may or not include the on-call psychiatrist or the Approved MH professional where a MH Act assessment is required. A member of Mental Health Crisis Team visits the custody suite every morning to liaise with the Police.

In North Lincolnshire the recognised Places of Safety are the hospital, Great Oaks and as a last resort the police station. The police station is not used routinely as a place of safety - only when there is a real risk of violence that could not be managed in an open hospital environment. Researchers found widespread differences in the knowledge and experiences of agencies when dealing with clients presenting with a mental health crisis.

The police reported that where an officer calls in a ‘136’ their Communications Team will contact the Crisis Team who advises whether the detainee should be escorted to Great Oaks or A&E. There is a perception that whenever alcohol is suspected, escort to A&E is advised and ‘sometimes it appears the MH professionals actively seek to identify a level of intoxication or they say it’s a personality disorder so they can’t do an assessment. Very rare do they assess them as having a mental health problem and section them, sometimes they may offer an individual voluntary access but sectioning is very rare’.

This indicates a lack of awareness of the criteria for sectioning under the Mental Health Act as opposed to identification of mental health issues that do not warrant sectioning but may still merit treatment.

The mental health service provider stated that all assessments take place at Great Oaks as the designated Place of Safety. Assessments at A&E would only be carried out in exceptional circumstances such as when the physical health needs of the client were a priority e.g. where someone had ingested something, had a fall or a head injury. An assessment must be carried out within 3 days of detention and mental health services reported that most are carried out within 4 hours and that this is monitored. Where an assessment is undertaken after 4 hours it is usually due to the individual being intoxicated.

Mental Health Act assessments must be carried out by a s12 Approved Doctor or approved mental health professional. The purpose of the assessment is to determine if the person should be detained under the Mental Health Act. Another outcome may be an agreement to be voluntarily admitted or that they require treatment in the community. Where a person does not have a mental disorder but other issues they are signposted appropriately. Locally there are instances where the detainee is known to mental health services but is assessed as not requiring admission. In these circumstances their Care Coordinator (often their CPN) is contacted to follow up with them and this may lead to a modification of their care or treatment package.

Where a person has been detained under a section 136 the mental health service has a statutory duty to carry out an assessment, a person cannot be discharged from a 136 until the assessment has been completed. Locally this means that where the detainee presents as intoxicated they will remain at Great Oaks (usually with the Police) until they have sobered up and the assessment can be completed. This can lead to tensions as mental health staff may not agree that someone should have been detained under the Act in the first place. Police interviewed acknowledged that in the past they had used Section 136
powers inappropriately as they didn’t know what else to do…”"Section 136 tended to be used by officers as there is currently a gap in the care in the community for people that don’t meet the criteria for admission to services; and a gap in knowledge around what mental health is and what a personality disorder is”

However, mental health services stated that in circumstances where a police officer believes somebody to be mentally disordered in a public place it is preferable for them to be detained for an assessment and discharged; rather than risk someone slipping through the net.

There is a local Section 136 monitoring group where the Police and RDASH meet to review activity and identify any issues. Where an individual has had several 136 admissions this is reviewed to identify what can be done to manage this which may result in a change to their care plan or the police taking alternative action such as taking them home instead of to Great Oaks. Significant investment has been made to provide all front line Police officers and PCSO’s in the division with Mental Health First Aid training. This has given officers the skills to use different strategies when dealing with people presenting with mental health issues in the community. As a result of these initiatives RDASH report that there has been a significant decrease in the number of calls for Section 136 assessments, and the Police confirm that they are just detaining now when a substantive offence has been committed.

Police locally reported feeling that they are the only service with a responsibility to these challenging individuals, and the difficulty for them is in how to deal with people who do not meet the criteria for other services but remain challenging and needy.

4.2. Courts and Diversion
i. Literature Review

Key Documents Reviewed
- The Corston Report; A review of women with particular vulnerabilities in the criminal justice system, Home Office, 2007
- The Bradley Report, Department of Health, 2009
- Offender Health: Scoping Review and Research Priorities within the UK, Report for Offender Health at the Department of Health, July 2009
- The Big Diversion Project: Current State Analysis of Diversion Services in the North East Region, Revolving Doors Agency, April 2012

Health
Defendants can present at Court with a range of health and social care needs, which are taken into account to ensure that they receive the most effective disposal, especially in relation to their mental health or learning disability. Disposal other than to prison is generally referred to as liaison or diversion and is generally used for those suffering from mental health problems or learning disability where it is deemed that alternatives to custody would be more appropriate.

Information about a defendant’s health is usually transferred from police custody (where an initial assessment takes place) to court staff through the Prisoner Escort Record (PER). This is designed to share information on the key health and wellbeing issues, which have been identified in police custody. These issues will include drug and alcohol use, physical and mental health and risk of self-harm. If the defendant has been assessed by a
healthcare professional whilst in police custody, then any confidential information obtained is attached to the form in a sealed envelope and only opened in an emergency. If the person is sent to prison then the PER form should follow. The usefulness of the PER in relation to health issues is dependant on the strength of the information gathering processes at the police station; frequently the PER form is unable to effectively inform court staff and is frequently lost (Revolving Doors\textsuperscript{72}).

### Mental Health

The Offender Health Scoping Review and Research Priorities document refers to three studies concerning the mental health of those appearing in court. During a three-month pilot mental health assessment of 57 people in a magistrate’s court in Leeds (Greenhalgh et al, 1996):

- the vast majority seen were male (89%)
- 82% were unemployed
- 77% were found to be suffering from a psychiatric disorder, notably schizophrenia (7%); bipolar disorder (7%); and personality disorder (12%)
- almost half were suffering from alcohol or drug dependence or misuse
- In 37 (61%) of the psychiatrists made a recommendation
- in three cases the psychiatrists recommended admission but there were no beds available, in the majority of cases psychiatrists recommended psychiatric outpatient treatments
- 43% were found guilty
- 30% were given a given a custodial sentence.

The authors concluded that there were several issues impacting on the effectiveness of the diversion scheme, these included a lack of psychiatric beds and also a lack of suitable accommodation in the community especially approved premises specialising in care for psychiatric problems.

A later study by Fiander and Bartlett (1997) aimed to identify levels of ‘missed cases’ in an ‘incustody’ population at a London Magistrates’ court, between May and July 1994. A random sample of 100 individuals taken from all those in custody on each interview day was selected for interview, of which:

- 35% were identified as alcoholics by their Brief MAST score
- 9% reported currently using heroin, cocaine or amphetamines everyday
- 25% reported a history of deliberate self-harm
- 8% were referred to the ‘duty psychiatrist’ scheme

- only 7.5% of those currently using illicit drugs were referred to the ‘duty psychiatrist’ scheme
- none of the alcoholics were referred to the ‘duty psychiatrist’ scheme
- only one of the seven individuals who had committed an act of deliberate self-harm in prison was referred to the ‘duty psychiatrist’ scheme.

The authors argued that in view of the possible physical, psychological and social problems that may stem from such drug and alcohol use, these individuals would benefit from a psychiatric assessment.

\textsuperscript{72} Development programme for extending offender healthcare support: Early Interventions, Revolving Doors Agency 2006
Shaw et al. (1999) undertook a study in Manchester Magistrates’ Court to examine the prevalence of serious psychiatric disorder - the study’s definition included schizophrenia, mania, other psychoses and depressive or other severe disorders (e.g. including suicidal ideas). They found that the frequency of serious psychiatric disorder was 1.31% among defendants appearing in court direct from the community and 6.57% among those held in custody overnight.

Of those interviewed, who had a serious psychiatric disorder:

- 34% had schizophrenia and other psychoses
- 55% had depressive disorders
- 76% of those with depressive disorders had suicidal ideas (which were recorded on the first-phase screening procedure in many cases)
- only 14.5% of those defendants who had been in overnight custody and had a serious psychiatric disorder were routinely detected by court staff and subsequently referred to the court diversion programme.

The authors concluded that there was a substantial rate of psychiatric disorder in the court population, which was not satisfactorily detected within the current system.

In their comprehensive report on Diversion Services in the North East, one of the Revolving Doors Agency’s key findings was that Courts needed “increased support and information from Criminal Justice Liaison and Diversion (CJLD) services to inform decision-making”.

They found that the limited coverage of CJLD services in the region resulted in information about a defendant’s health needs and how these might affect the court process came from one of two sources (p.17):

- from the police via the prosecution, or
- from the defendant via the defence solicitor.

The authors found general concern that sources of information were indirect and often incomplete - “Defendants might withhold information due to concerns regarding stigma or negatively impacting the outcome of the case and although perceived as a good source of information, defence solicitors usually only passed on information when it was preferable to the defence” (p.17)

They also found that the focus of Criminal Justice Liaison and Diversion provision in the region was on those clients who were being held in police custody or in the cells attached to the court. The authors point out that severe mental illness or learning disability is not confined to those who had committed serious offences. Several Deputy Justice Clerks interviewed for the project “highlighted the lack of provision for identifying and informing the court of the mental health needs or learning disability of a defendant who appears in court on summons or on bail” (p.17)

The study noted that many defendants were not held in either police custody or in the cells, or were only held for a short time, when there was no Criminal Justice Liaison and Diversion service in operation. The need for a mental health professional in court to proactively screen this group and provide immediate advice to courts was identified.

---

73 The Big Diversion Project: Current State Analysis of Diversion Services in the North East Region, Revolving Doors Agency, April 2012
Among the study’s key findings concerning the Courts process were:

- a move towards Fast Delivery Reports from probation resulted in reduced opportunities to identify need and therefore the court was provided with less detailed information (although full reports were normally requested if a mental health problem had been identified).

- discontent with the current practice around provision of formal psychiatric reports to courts:
  - “finding a psychiatrist willing to produce the report within the statutory cost restrictions”
  - “time taken to complete these reports”
  - “communication between probation and court authors regarding the content of the report”
  - “sentencing implications, and quality and relevance of these reports”
  - identified need to “recognise the impact of mental health problems and learning disabilities on the defendant’s engagement with the court process”.

- where mental health needs or learning disabilities were identified there was felt to still be “a risk of Magistrates up-tariffing sentences for offenders in order to facilitate access into treatment” and equally there was concern around “the practice of down-tariffing sentences so that problematic behaviour went unchallenged (highlighted as a particular problem for those with learning disabilities)”.

- a need to clarify the processes around Mental Health Treatment Requirements (MHTRs)

The Big Diversionary Project reported that national research had shown that Mental Health Treatment Requirements are used infrequently, when compared with the number of other orders used and the proportion of offenders who have mental health conditions. This picture was mirrored in the region covered by the Big Diversionary Project. The Big Diversionary Project survey of probation found that “72% of respondents said that they would infrequently or never consider recommending a MHTR to the courts for defendants with a mental health problem or learning disability”. They identified a number of barriers:

- “uncertainty over which mental health conditions it may be appropriate for”
- “difficulties associated with obtaining psychiatric reports”
- “unfamiliarity of procedures associated with MHTRs in general”
- “significant lack of knowledge around making, operating and enforcing a MHTR among respondents: 51% said that they were fairly or very unknowledgeable in making; 56% in operating; and 63% in enforcing a MHTR”.

In his 2009 report\(^74\), Bradley commissioned Rethink to host focus groups for service users and carers who had experience of the criminal justice system. One of the key concerns raised by the group was in relation to the knowledge and experiences solicitors and, in particular, duty solicitors have of mental health issues. Service users whose cases were handled by a specialist mental health solicitor reported better outcomes than those who were not.

\(^{74}\) The Bradley Report, Department of Health, 2009
Homelessness is often a trigger for offenders to be dealt with differently at the police and court stages and influences decisions to grant bail and apply a community sentence. Bradley found no data to identify how many individuals are remanded in custody pending a psychiatric report, how many are assessed as having a mental health problem, and how many are so unwell that they require transferring out of custody for treatment.

Bradley also found that health services in prisons had improved with investment in mental health in-reach teams, substance misuse services and a focus on primary care and assessment. However, he reported that remand does not offer much time to engage with treatment, and where prisoners on remand are released directly from court there are significant difficulties in ensuring continuity of care from custody into the community.

**Learning Disability**
The Offender Health Scoping Review and Research Priorities report finds that “little research has been conducted on the prevalence of learning disabilities in the court system.” The report references Purchase, McCallum and Kennedy (1996) who evaluated a scheme at Tottenham Magistrates’ Court over an eighteen-month period, between July 1993 and December 1994. 104 defendants were seen and data on 89 people were reported. Of these, only two defendants were identified as having learning disabilities.

A subsequent study by Talbot & Riley (No One Knows 2007) was based on interviews with 11 people with learning disabilities who had contact with the criminal justice system. The study reported that the most common issues faced in courts by participants were:

- not being able to understand words used
- not understanding what was happening during their court appearance and
- not understanding what the outcome of their court appearance might be.

Bradley also found that there were few studies with sound methodologies looking at prevalence rates of mental health problems or learning disability in those presenting at courts.

People with learning disabilities can have specific issues in relation to the court environment that require support. There are support measures for vulnerable victims and witnesses under the Youth Justice and Criminal Evidence Act 1999 in place and Bradley recommended that these be extended to include vulnerable defendants.

After a first court appearance magistrates decide whether to remand on bail or in custody. Both Magistrates’ Courts and Crown Court have the option under S35 of the Mental Health Act to remand someone to hospital for psychiatric reports. Bradley found a heavy reliance by the courts on remand to prison as a ‘place of safety’ for vulnerable defendants as the Police, Probation Service and courts were unclear about the availability of other alternatives.

In A review of women with particular vulnerabilities in the criminal justice system (2007), Corston (p.2) advocates for a “fundamental re-thinking about the way in which services for......vulnerable women, particularly for mental health and substance misuse in the community, are provided and accessed.”

---

75 The Bradley Report, Department of Health, 2009
76 The Corston Report; A review of women with particular vulnerabilities in the criminal justice system, Home Office, 2007
Liaison and Diversion and Non-custodial sentencing
Corston makes a strong argument for a greater provision of alternatives to custody for women especially community-based options. During the course of her review she visited 3 community centres which work to support women with particular vulnerabilities to take control of their lives, and recommends that such centres should be established within every health authority area as non-custodial alternatives for sentencers. She quotes an independent evaluation of one of the centres (218) for the Scottish Executive Justice Department: “Interviews with sentencers and prosecutors have shown that they make use of 218 and value it as a resource. In individual cases, referrals to 218, such as through diversion from prosecution or direct bail, often successfully prevented female offenders from entering custody, at least in the short-term. Quantitative and qualitative data indicate that women who have engaged in services at 218 have been actively involved in offending and that they fit the profile of female offenders in custody. So it is likely that women who engage with services at 218 are avoiding custody in the short and longer term”.

Bradley found that training for probation staff, including those working in approved premises varied and was commissioned at a local level and that probation staff were unsure of how they should manage offenders with mental health problems and what local healthcare services they could refer clients to.

Bradley identified two practice examples:

Bracton Centre Forensic Mental Health Service funded by the Inner London Probation Service offers specialist hostel provision for high-risk personality-disordered offenders in partnership with Mental Health Services to bridge the gap between mental health and criminal justice services for offenders at high risk of social exclusion due to their challenging behaviour and psychological needs.

Kew Hostel in Surrey provides accommodation for men who have served long-term prison sentences for serious, often violent offences. Due to their previous convictions, conditions of licence, and particular health histories and needs, the client group may also be seen as a risk group for the registering practice and its patients. As a result, a service specification has been agreed between the Probation Service and the local PCT that outlines the specific responsibilities of the approved premises and the GP practice. The practice will participate in a health needs analysis of the hostel population every two years, and will work with the PCT in reviewing the service specification, in order to ensure service provision that meets the primary care needs of the client group.

Bradley found that stakeholders wanted to see an increased use of bail for mentally disordered offenders, whom they felt should only be remanded in custody when absolutely necessary; ”However, there does not currently appear to be appropriate provision of mental health services to support individuals who might be housed in approved premises, and this lack places an unnecessary strain on probation officers, who may be untrained in mental health awareness” (p.68)

A study for the Yorkshire and Humberside Improvement Partnership77, found that in the Yorkshire and Humber region, three court schemes had ‘lapsed’ since the publication of Lord Bradley’s report. In each of these three cases the author found that the scheme was

---

77 Courts, Liaison and Diversion Scheme Profiles Yorkshire and Humber Region, Yorkshire and Humber Improvement Partnership 2010
down to a single practitioner who had either retired or vacated the post, with resources diverted elsewhere as it was not seen as a priority by the local mental health provider. However, the report refers to many examples of efficient multi-agency working in the region and states that examples of good practice in the Yorkshire and Humber region tend to be based on good working relationships and local understandings but reliant on individuals, who could move on or retire, risking an end to such joint working.

Robust multi-agency information sharing protocols are rare - where information sharing exists it is as a result of “shared understandings of risk assessment issues and conjoined priorities”. The confused state of IT based records and information used by mental health services is identified as a problem, with no consistent system used across the region. Where the same system is in use, staff in a different location cannot access the details of a particular case as systems are stand alone. The same problem occurs with in the prisons with System One. The report says that the Department of Health are pursuing IT based solutions to these issues, but that they could be years in the making and given the nature of some high-profile IT failures this move may not be fully supported by Government, given the financial climate.

The report finds that the Offender Assessment System (OASys) is used almost throughout the criminal justice pathway - from first time offenders at court stage and continues to exist for repeat offenders. The report states that it is the “backbone of the end-to-end offender management process and, although not suitable for storing clinical records, it is ideally suited for recording pertinent information regarding an offender’s emotional state, health and wellbeing”. The report goes on to say, that used correctly “as the spine of an effective Criminal Justice Liaison and Assessment service it could provide a conduit for all relevant information including that relating to mental state (past and current), previous diagnoses (including learning disabilities, particularly if the LDSQ (Learning Disability Screening Questionnaire) is fully adopted by probation services) and CPA (Care Programme Approach) case details”.

The author found that in some areas this arrangement exists to some extent, stating that the Integrated Offender management (IOM) model provides much of the infrastructure required and could provide multi-agency expertise in all areas except for mental health and learning disability. At the moment this expertise has to be sourced from “reluctant local service providers on an ad hoc basis, or more rarely, from a seconded practitioner”. He suggests that the current lack of court scheme provision could be addressed, but must widened to include police custody and neighbourhood policing as key points in the criminal justice pathway. He suggests that the scheme should be jointly commissioned between Community Safety Partnerships, Reducing Re-offending partnerships, local Health Boards, Offender Health commissioners, local Criminal Justice Boards and relevant third sector agencies working together to provide joint solutions, with multi-agency governance to oversee the process.

ii. Stakeholder Engagement

Pre Sentence Reports
Several of the stakeholders interviewed liaised with Probation to contribute to the development of Pre Sentence Reports (PSR) for offenders. This might take the form of assessing a defendant’s suitability for a Drug Rehabilitation Requirement (DRR), Alcohol Treatment Requirement (ATR) or Mental Health Treatment Order (MHTO), or reporting on engagement and progress with a range of programmes which are deemed to be beneficial in reducing offending or part of a requirement for those serving a community sentence. However, there was some concern expressed “We like to think that our intervention with
the client is added into the PSR, but we don’t often get phone calls asking for our input. We have pertinent information to provide in terms of motivation and progress with their recovery journey.”

Probation reported that they had developed a “fast and lean” PSR process to avoid long periods on bail or remand. This included providing an oral report within very short time scales and tapping into information already held.

Gathering medical information for the PSR was considered to be ad-hoc, requiring an element of self declaration by the offender, who then needed to give written consent for their medical records to be accessed. The reliance on professional relationships rather than a set protocol for accessing medical information was seen as problematic.

Problems with the lack of clarity or guidance around Psychiatric reports - particularly who pays for them and the length of time taken to produce them, was mentioned by more than one interviewee. This resulted in the offender being remanded in custody or on bail until a report was available, and there was concern expressed that once complete, the reports were not always readily available even though they played an important contribution to the PSR and Probation’s recommendations for sentencing. Whilst RDASH liaised with Probation they found that courts would sometimes write directly to their consultants and request a report. In addition to requests from the courts for Psychiatric Reports, requests could also come from the defence solicitor.

The Mental Health Trust identified that the majority of their work in relation to offenders was in providing the courts with information for sentencing. Some offenders would be required to complete certain mental health interventions as part of their sentence and RDASH would be responsible for delivering those as long as it was a commissioned service. However, RDASH felt there were occasions on which courts have made recommendations for inappropriate or non-commissioned services, which then prove difficult to deliver, necessitating a request to the CCG for additional funding to provide them.

With regards to information sharing, RDASH stated that they felt that a lot of the information requested would be in the public interest and therefore there was no requirement for consent. They also pointed out that they would not share information which was not relevant. Unfortunately, there appears to be little understanding or clarification amongst partner agencies as to the criteria used for such decisions.

Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) Assessments for Alcohol Treatment Requirements (ATRs) and Drug Rehabilitation Requirements (DRRs) are undertaken locally and appear to be working well:

“We have dropped everything on a phone call from Probation asking us to come down and assess someone straight away, because they are about to go to court - every time bar one we have managed to accommodate that”, and

“we are requested to provide a report on their suitability for DRR, ...we contact them within 3 days of their court appearance”.

Both agencies involved have access to on-site medical professionals who conduct a broad health and wellbeing assessment:

“We then take them through our Induction process, where we look at their health needs, family issues, past substance misuse etc etc.”
This is against a backdrop of increased demand and all agencies involved reported a willingness to respond rapidly when required to expedite the process, this included providing verbal reports and video-conferencing:

“If the court stands down because an assessment is required, we will usually give a verbal report. The verbal report is given to the court team who echo the finding in the court process”.

**Mental Health Treatment Orders (MHTOs)**
The prevalence of Mental Health Treatment Orders in North Lincolnshire was described as low, but stakeholders could not provide the exact numbers. It would appear that most of the time these orders are made when offenders are already receiving treatment from MH and the order just reflects that.

“That part of the offender pathway is not really established at all - the order does not stipulate how the MH side of the treatment order works and does not appear to be any standards in place to measure how effective these can be”.

Concerns around the use of MHTOs were reported by other agencies. The lack of information around any standards or ability to measure effectiveness “no information as to how offenders fare on these” was raised as was the issue around diagnosis which meant that cases had to be adjourned, which in turn resulted in offenders spending longer in custody or on bail.

There was reported to be a lack of robust formal links between services to facilitate early intervention and assessment and a poor correlation between those offenders with mental health problems and prevalence of MHTOs.

There was a view expressed that entry into mental health services should remain voluntary unless sectioning was required, yet a MHTO made treatment a mandatory condition.

The lack of protocols for joint working to facilitate and support offenders on MHTOs was raised, and their management by Probation but delivery by RDASH proved problematic for some.

MHTOs can require treatments that are not available, not appropriate, for a longer time period than is available or which do not meet NICE guidance or standards and there was a perception that MHTOs were more difficult to deliver in North Lincolnshire.

“Sometimes the court will order someone to complete a particular therapy that we are not commissioned to provide. Sometimes it might be about the time - we will do interventions based on NICE guidance interventions which may be for a certain number of sessions - sometimes the court may say this person has to engage in therapy for two years and we don’t provide that length of intervention”.

Disagreement as to which service should pay for the psychiatric assessment and additional difficulties experienced when a MHTO is accompanied by a DRR or ATR further complicated the concerns around MHTOs.

**Diversion and Liaison**
There is currently are no formal arrangements for Diversion and Liaison in North Lincolnshire. However, Humberside Police and partners have recently launched a Restorative Justice Project as an alternative to court by focusing on reparation instead of
punishment for people arrested for low level violent offences with no previous history of violence. A Probation Officer will carry out a triage to assess offender needs and prepare them for the restorative justice process. The process can involve making physical reparation such as cleaning off their graffiti and restorative conferencing – where the offender is brought into contact with their victim to apportion blame and instil feelings of guilt. An offender must be mentally capable of going through the process, if they are not considered suitable the case is sent to the Crown Prosecution Service to determine whether to proceed in the CJS. The project also provides an opportunity to link offenders with health services for example if they had assaulted someone due to being drunk they would be signposted to the alcohol service and this would form part of the be part of the Restorative Justice process.

4.3. Probation and Community Sentences

i. Literature Review

Key Documents Reviewed:

- Offender Health: Scoping Review and Research Priorities within the UK - July 2009 (OHSR 2009) Report for Offender Health at the Department of Health: Charlotte Lennox, Dr Jane Senior and Professor Jenny Shaw - Offender Health Research Network; University of Manchester
- (Bradley) Bradley Report - Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system, April 2009
- (Merseyside HNA) Health needs assessment of adult offenders across the criminal justice system on Merseyside, June 2012 - Cath Lewis and Alex Scott-Samuel, Liverpool Public Health Observatory
- The Big Diversionary Project - Current State of Analysis of Diversion Services in the North East Region: Revolving Doors Agency April 2012

Background

“Offenders in the community find it difficult to access appropriate care services. Health needs often go unmet or are met through inappropriate means” (DH, 2007). The total annual probation caseload which includes court orders and pre and post release supervision was 224,823 at the end of 2012. Meeting the health needs of offenders in the community is the responsibility of Health and Wellbeing Boards and this includes Approved Premises such as Bail Hostels.

A summary version of an offender’s health information is documented using the Offender Assessment System (OASys), completed by Prison Service staff on discharge or by Probation staff in the community. With regard to health matters, OASys asks questions about suicide, self-harm, childhood behaviour problems, head injuries, mental health problems, psychiatric treatment and emotional wellbeing. Probation staff will not have direct access to offenders’ NHS information, either those held in the community or prison based clinical records.

---

Prevalence of health issues amongst offenders on Probation
Researchers have consistently identified that health needs, drugs and alcohol play a significant role in the lives of offenders in the community and therefore needed to be taken into account by probation officers in their work with offenders both at the assessment stage and as part of supervision.

Mair and May (1997) interviewed 1213 offenders on probation with regards to health problems. The study found that the proportion of offenders on probation reporting health problems was similar to that reported by offenders in prison and higher than found in the general population:

- 49% said that they currently had or expected to have certain long-term health problems or disabilities
- common problems were musculoskeletal, respiratory and mental health problems
- almost a third of probationers interviews said that health problems limited the work they could do
- 42% reported using cannabis in the previous 12 months
- 24% had used amphetamines, 15% Temazepam
- 14% LSD and 12% Ecstasy, 10% magic mushrooms
- 8% heroin, cocaine and methadone, 5% crack cocaine.
- 10% reported having a drink problem.

There was much higher reported prevalence of alcohol misuse identified by Newbury-Birch (2008) who found the that 69% of men and 53% of women in contact with probation were classed as having an alcohol misuse disorder compared to 59% of men and 63% of women in custody.

Death and Suicide
Research indicates that people on probation and those recently released from prison are at greater risk of suicide than the general population. Pritchard et al. (1997) explored the mortality rates of a six-year cohort of male probationers (1990-1995) and compared death rates with males in the general population and found that the suicide rate of men on probation was almost nine times greater than that of the general population.

Sattar (2001) collected data on offenders who died between 1996 and 1997 while under community supervision or in prison, covering 1267 community deaths and 236 deaths in prison. Of the community offenders, 20% were the result of natural causes, 22% suicide, 33% accident/misadventure, 17% other drug and alcohol related, 6% homicide, and 1% other violent death. They found that community offenders were less likely to die from natural causes and suicide than prisoners but had higher rates of death for all other causes. All deaths involving drugs or alcohol were combined and these accounted for 46% of all deaths in the community and 3% in prison.

Mental Health
Huckle et al. (1996) investigated a psychiatric clinic based in a probation service in South Wales and concluded that the psychiatric probation order proved a useful way of accessing appropriate health care for people who were at serious risk of a custodial sentence, and psychiatric clinics based in probation offices were deemed to be a success as far as the probation staff and clients were concerned.

Hatfield et al. (2004) reported on a 12 month cohort study of mental disorder among residents of approved premises within Greater Manchester. Just over a quarter of the residents had a known psychiatric diagnosis, with 41% of these having a known secondary diagnosis. Five per cent had a diagnosis of psychotic mental illness. In addition 9.4% had
literacy problems, 18.8% had one or more physical health problem, 4.9% had a Learning Disability, 30% had a problem with alcohol misuse and 34.3% a problem with drug misuse. Men known to have a history of mental illness were directed into specialist premises; however, others were placed in non-specialist services. Depression and substance misuse were identified as significant problem areas for residents.

**Mental Health Treatment Requirement**

In 2005, the Community Order became the new generic community sentence available to the courts as an alternative to prison. The Community Order gives a choice of twelve different requirements these include unpaid work, supervision by an offender manager or probation officer, accredited programmes, drug and alcohol treatments, mental health treatment, residence at approved accommodation, specified activity, prohibited activity, exclusion for certain areas, electronic curfew, or attendance centre.

The Mental Health Treatment Requirement (MHTR) can be issued to offenders who have an identified mental health problem, where treatment is readily available and the offender has given their consent to engage with services. The order must be managed by an offender manager, and it must be conducted under the direction of an appropriate medical practitioner.

During 2006, 121,690 Community Orders were issued in England and Wales, 85% of Orders comprised one or two requirements. The two most frequently used requirements were Supervision (37%) and Unpaid Work (31%). Just 19 of the 60,253 single requirement orders issued in 2006 were MHTRs. Seventy-two per cent of all MHTRs used with a Community Order were combined with Supervision. Reasons hindering the use of MHTRs, included problems deciding on the seriousness of the mental illness, difficulty in accessing psychiatric assessments and problems with people with dual diagnosis. (Seymour and Rutherford, 2008).

Khanom, Samele and Rutherford (2009) conducted research to explore the MHTR by conducting interviews with 56 professionals from the courts, probation and health services, including voluntary sector agencies and court diversion and liaison services. The interviews revealed a general lack of awareness of the MHTR and a lack of knowledge of mental health.

Court and probation professionals varied widely in their knowledge of mental health issues and their confidence in dealing with them. Judges were the most likely to say they had sufficient knowledge of mental health for their job. Magistrates felt that the training they received was minimal. Some probation officers said they were not so confident in managing cases where offenders have mental health problems and that there is not enough training on mental health. In addition, issues around responsibility for mental health were raised with many of the court professionals interviewed of the view that mental health was not the business of the CJS.

The authors conclude that the MHTR needs substantial reinvigoration and reinvention as a recognised and utilised noncustodial option for people who would otherwise be imprisoned on short sentences. They recommended that criminal justice and health professional be provided with practical guidance on how to use and manage an MHTR. Protocols at a local level need to be developed between the courts, probation and health services to enable the appropriate use of the MHTR. They also cited a need for better mental health training for all criminal justice professionals.

In 2009 Lord Justice Bradley also identified the need for more effective use of Community Orders for mentally disordered offenders. He recommended further research on the use
of mental health treatment requirements, calling for the development of a service level agreement between Her Majesty’s Courts Service, the Probation Service and the NHS to ensure the necessary mental health provisions for Community Orders are available; and that there is clear guidance for sentencers and probation staff regarding the use of mental health treatment requirements.

Bradley notes that the 2008, the National Audit Office (NAO) reported that 6% of cases reviewed included an MHTR. In all of these, the offender was already receiving treatment and this was incorporated into the order. He commissioned a cost/benefit analysis to examine the impact on prison places should there be an increase in the use of Community Orders for people with mental health problems and learning disabilities and found this would suggest significant cost savings of up to £40m per year would be made for the criminal justice system.

Learning Disability
The Big Diversionary Project (2012) found confidence of survey respondents in identifying a learning disability was lower than that in identifying mental health conditions:

- 67.5% of probation respondents said that they felt very or fairly confident in identifying a mental health condition among their clients
- 59.6% said the same about identifying a learning disability
- 42.9% of respondents agreed or strongly agreed that they had the knowledge and skills to meet the needs of their clients with a mental health condition
- 40.2% of respondents agreed or strongly agreed that they had the knowledge and skills in terms of a learning disability

The survey of probation staff found that:

- 64.8% reported that they knew where to access help to assist them in managing an offender with a mental health problem
- 40.5% reported that this was the case for offenders with learning disabilities

Probation staff identified wanting social care support for their clients and advice on how to approach work on offending behaviour with clients who have a learning disabilities. However, requests for training were found to focus more on practical advice around service provision locally and referral pathways. A number of respondents also highlighted difficulties with clients falling through gaps in between different services or failing to meet high service thresholds, with dual diagnosis and personality disorder highlighted as posing particular challenges.

Loucks (2005) identified “Few community-based services for learning disabilities in the UK are set up specifically to address offending, and few programmes for offenders or addiction services have been adapted for people with learning disabilities or learning difficulties”. There are further problems for those with borderline learning disability. Not only is this less likely to have been picked up by criminal justice agencies, but many community LD services work with strict, IQ based definitions of learning disability in their referral system."

Mason and Murphy (2002b) examined intellectual disability in 90 people on probation in south-east England. They were screened using the Learning Disabilities in the Probation Service (LIPS) screening tool. The LIPS includes two measures of cognitive functioning, as well as some questions about day-to-day coping skills, self-report questions relating to education, intellectual disability and mental health needs, and demographic information. They found that participants with intellectual disability were significantly younger and had an earlier age of first conviction. They also more likely to offend with peers, and less able
to carry out some of the tasks which are likely to be essential to a successful outcome, such as ability to keep appointments and follow the probation service rules.

**Black and Minority Ethnic Groups**

The Big Diversionary Project (BDP) cited previous research ((Jacobson, Phillips and Edgar, 2010) which has raised concern about the over-representation of BME groups in mental health and learning disability inpatient care and the routes by which those from BME communities access mental health services, in particular the higher proportion of those accessing such health services via the criminal justice system.

BDP found that “although language barriers were acknowledged as an issue, responses from regional stakeholders suggested that BME groups were not considered a key priority for local agencies.” The low BME populations in the North East were cited as a reason for this by some, which did however raise concerns about a lack of knowledge amongst stakeholders of cultural issues.

Hatfield’s 2004 study of offenders in approved premises found that black and minority ethnic communities were under-represented in the group with mental disorders and that further research to establish why this was the case was needed to ascertain if it may be the result of under-identification.

**Women**

Merseyside HNA noted that during 2011/12, 80 women received conditional cautions for a range of offences. 66% of which involved shoplifting and 14% possession of drugs, with a condition to attend either Together Women, a community-based intervention which aimed to reduce re-offending among female offenders and address the needs of women ‘at risk’, or the Turnaround Project, which provides support for female offenders or those at risk of offending. Out of the 80 cases, only 17.3% re-offended, with a breach in only one case, equating to a success rate of 80%.

The research found that women offenders were sometimes reluctant to access services where they were the minority service-user and that services that were specifically targeted at female offenders, including the Turnaround Project and Tomorrow’s Women Wirral, were highly valued by both offenders, and staff, in terms of meeting health care needs. Women were supported to keep families together in a way that they would not have been had they been sent to prison. They were able to access services under one roof, including access to benefits and legal advice, confidence building/assertiveness and job skills, that would help prevent re-offending. Women were also able to get basic needs met, e.g. they were able to get food, and had access to a washing machine.

In March 2013, the government set out four key work streams for rehabilitation for female offenders. These included enhanced provision in the community which recognises and addresses the specific needs of female offenders, where these are different from those of male offenders; and implementing a whole system approach - “Through the transforming rehabilitation programme, supporting better life management by female offenders ensuring all criminal justice system partners work together to enable women to stop reoffending.”

---

80 The Parliamentary Under-Secretary of State for Justice (Mrs Helen Grant): Hansard 22 Mar 2013 : Column 63WS
Accessing health and social care services

The Big Diversionary Project report identified some problems trying to “engage this client group in the community where they are ‘uncontained’ and where frequently chaotic lifestyles can inhibit engagement”; and identified the need for more creative approaches to strategy development for this client group.

A pilot in the Darlington area was identified as promising; where clinics will be provided by Talking Therapies (the local IAPT service) within the offices of probation and the Youth Offending Service offering both assessment and Cognitive Behavioural Therapy (CBT) based interventions.

East Sussex HNA also found that offering offenders leading chaotic lifestyles appointments weeks in advance often results in non-attendance and that there is a perception that it is not worth following-up non-attendance for appointments and meetings. Offenders often find themselves of being in contact, or needing to be in contact, with a number of different services being delivered by a number of different organisations sited in a variety of locations. Researchers found that partnership working between these services is patchy across the county and a suggestion that people are ‘pushed around the system’.

East Sussex HNA called for ‘drop-in’ style services to be considered, both in the development of new services and in the review and redesign of existing services and the co-location of different outreach services as a method for increasing attendance and improving linkages between services. The probation service identified itself as a prime location for the delivery of outreach services as many offenders are required to attend as part of their orders. The HNA also identified that need for:

- Advocacy services to assist people with accessing and navigating their way through services
- Linking the work undertaken within the county in relation to deprivation and addressing inequalities with work to meet the health needs of offenders
- Developing health promotion and service information in such a way that these become accessible and that this should include the potential use of non-written media

Information Sharing Protocols/inter-agency working

Probation staff interviewed for the Big Diversionary Project report said that without clear information sharing policies, they are reliant on their own discretion to determine what to share. Almost two thirds of probation staff responding to the BDP survey said that they were “not aware of any formal protocols regarding what information is shared about an offender’s mental health problems or learning disability.”

The BDP did identify that the Probation Trusts and health interviewees participating recognised partnership working as important and that services were “responding well to those who were considered to present a high risk of harm”. These offenders are normally subject to Multi-Agency Public Protection Arrangements (MAPPA), however, it was suggested that the Integrated Offender Management (IOM) could be a means to improve multi-agency support for repeat offenders with mental health problems or learning disabilities. Having the right people around the table was identified as important in such circumstances, but the study found no evidence of “any strategic partnerships in place involving probation that allow joint-commissioning of services to support offenders with mental health problems.”
The Offender Health Scoping Study (2009)\(^{81}\) identified a number of research priorities for probation including:

- Need for more work on the prevalence of health problems in the community with sexual health, alcohol and gambling as three areas where there is a lack of current research knowledge
- OASys is not sufficient to gather health information, and that ways of improving the gathering of routine data should be examined, to increase its usefulness
- More research into ‘what works’. Particular concerns were expressed that a large amount of money had been invested in drug intervention programme, but with no corresponding evaluative element.
- Need to examine the best ways of delivering services to people with lower level mental health problems, rather than focussing solely on the severely mentally ill.
- More research into how to motivate people to engage with services, especially the potential value of peer support schemes.
- Need for research on the efficacy of mental health treatment orders
- Need to examine the training implications of delivering more efficient or new types of services was regarded as vital; in particular the issue of ensuring adequate risk management training.

And concluded that - “In order to be able to deliver sufficient appropriate healthcare services it is necessary to have comprehensive, accurate information not only about the prevalence of physical and mental disorders along the whole offender pathway, but, most importantly, how this translates into identifying needs for particular services.” (p.63).

ii. Stakeholder Engagement

As of March 31st, 2013 Humberside Probation Trust were supervising 558 offenders either on a Community Order or Licence in North Lincolnshire; of those 482 (86.4%) were males and 76 (13.6%) females, 532 (95.3%) White, 17 (3%) Other and 9 (1.6%) Not Stated or Refused.

A court may sentence an offender to a Community Order for a maximum of three years. These orders contain one or more of the following requirements that the offender must undertake:

- Unpaid work
- Supervision
- Specified activity (eg literacy or numeracy training)
- Prohibited activity (something the offender is not allowed to do)
- Exclusion (an area where the offender is not allowed to go)
- Curfew
- Accredited Programme (offending behaviour group work)
- Attendance centre (for young offenders only)
- Drug rehabilitation
- Mental health treatment
- Alcohol treatment
- Residence (the offender must live in a specified place)

---

\(^{81}\) Offender Health: Scoping Review and Research Priorities within the UK - July 2009 (OHSR 2009) Report for Offender Health at the Department of Health: Charlotte Lennox, Dr Jane Senior and Professor Jenny Shaw - Offender Health Research Network; University of Manchester
When an offender receives a Community Sentence, they are allocated an Offender Manager who is responsible for delivering and enforcing the sentence. The offender manager ensures that the offender attends all appointments and fulfils all the requirements. If the offender ‘breaches’ - fails to attend an appointment without good reason or does not comply with the requirements - they are returned to court where they face further requirements being added to their Order, or imprisonment.

In all custodial sentences of 12 months or over, offenders are released subject to a statutory licence with standard conditions, supervised in a similar way to that of a Community Sentence. Prior to release, the Offender Manager will assess the need for any additional licence conditions. These may involve requirements such as exclusions from particular areas, prohibited contact with named persons or requirements to complete specific interventions such as offending behaviour group work programmes. The inclusion of additional licence conditions have to be assessed as necessary and proportionate to reduce the risk of further offending and protect the public from harm.

The Integrated Offender Management (IOM) scheme was developed within Humberside Probation Trust as a way of identifying currently most active offenders, particularly in relation to acquisitive crime. Offenders managed within the IOM scheme are identified and managed using a multi-agency approach. All offenders within the scheme have a nominated Probation Offender Manager and Police lead who have overall responsibility for the direct management of the offender. The IOM team is based at Shelford House.

Adult Services commissions Housing Related Support Services (HRS) and part of their role is to work in a multi-agency way to meet offender needs. Humbercare has the housing related support contract for offenders in North Lincolnshire with 250 clients on the books about one-third of these being offenders. Offenders can be assessed to receive high level HRS (up to 5 hours per week), Low Level (2 hours per week) or Befriending Services (1 hour per week) according to level of need. Humbercare also delivers a Volunteer Mentoring service separate from housing related support, aimed specifically at offenders, with referrals made through Probation.

Yorkshire and Humberside Circles of Support and Accountability is a community response to sexual offending, working in partnership with criminal justice agencies to reduce the risk of future sexual offences by supporting individuals who have committed sexual offences previously.

The Pathway Development Service (PDS) Yorkshire and Humber works to develop pathways for service users with Personality Disorders, providing training for multi-agency groups of staff; care reviews for service users in or likely to require secure hospital treatment; and consultation and advice to criminal justice staff. The service provides of a team of psychologists and semi-specialist probation officers; led by a clinical psychologist and senior probation officer - the PD Offender Pathway Partnership (PDOPP). The team aims to help probation staff to understand the importance of relationships in offending behaviour with PD and feel better equipped to use their own supervisory relationship with an offender to help them understand complex and often baffling presentations.

Third Sector organisations play a key role in supporting offenders in the community. These organisations develop good relationships with their clients and have extensive knowledge of their needs. Offenders may be more inclined to disclose information to these organisations than they will with statutory providers. These organisations also provide a vital safety net for a significant number of people in the community who fail to meet the criteria to enter statutory services.
Conway House is an 8-bedroom property operated by Sanctuary Supported Housing which provides accommodation and support for offenders. Once with Conway House staff will work with an offender to address their health issues such as accessing a GP, Dentist and an optician. The support is supposed to be short term and staff work with the Prolific Offending Team, Probation and Humbercare to support offenders in gaining the skills and attitudes to move into unsupported accommodation. In North Lincolnshire, there is a severe shortage of suitable and affordable accommodation in the private sector to move on to and as residents are predominantly young, single males with no dependents, they are not a priority for social housing.

The Empower North Lincs Programme is funded by the Department for Work and Pensions Job Centre Plus. The programme connects a range of locally provided services to assist offenders and ex-offenders to overcome barriers into employment: these barriers include accommodation; finance, benefits and debt; confidence and self-esteem; health and mental health; substance misuse and transport. The Programme engages individuals and works with them following established ‘buddying’ principles, working with offender managers/case managers in current services and enabling successful completion of individual resettlement aims and objectives under the supervision of the Empower Coordinator.

Scunthorpe and District MIND is a local independent mental health charity affiliated to the national MIND organisation. Scunthorpe and District MIND have a partnership agreement with Humberside Probation Trust who refer offenders coming to the end of their Order to MIND to access their services. Services available include a peer support centre, coping with life and Wellness Recovery Action Plan (WRAP) courses - which have been delivered to probation clients on a one to one basis - and a listening service.

The Forge Project is a homeless day centre run on a volunteer basis. As well as providing a meeting and information point and access to computers, The Forge Project also provides a light breakfast on four days each week and on three days they provide a hot lunch. The majority of the Forge’s clients are offenders or ex-offenders and are either rough sleeping, sofa surfing or living in privately rented-shared accommodation with minimal facilities. The project has recently experienced a sharp rise in the numbers of people accessing their services.

**Accessing health services**

Several stakeholders reported difficulties for some of their offenders in accessing GP services as they have been banned because of their inappropriate behaviour. Some of these offenders are required to access health services at Open Door in Grimsby. A number of organisation stated that as well as sign-posting offenders to health and other services, we also accompany them if they had the capacity to do so.

“If we identify that they are not attending their GP, we will go with them. If they have problems with drug or alcohol use, we tend to find that they don’t always get listened to by their GP. If we attend with them we can advocate for them and be more assertive on their behalf, so that their health problems don’t get overlooked because of the presumption that it is drug or alcohol related.”

One of the biggest concerns highlighted by third sector organisations participating in the study was the impact of Welfare Reform for their clients’ and their own resources.

“We’re finding that we are spending a lot of time at the moment with clients who have been sent from i2i and other places to do Job Search. They have to do Job Search to get their benefit or else they are sanctioned. A lot are struggling with
learning difficulties and no-one seems to be picking this up. We had someone last week with chronic dyslexia and there was no way they could manage on the computer to get themselves sorted... It takes about an hour of intensive work with someone to get them set up on the Universal Job Match (site)."

If clients fail to comply with their Work Programme requirements they are sanctioned and their benefit money stopped. Offenders with complex needs leading chaotic lives are particularly prone to sanctioning in this way. Many people struggle to comply with the work programme because of a lack of skills and basic understanding of what is required of them.

Job seekers are now required to log onto the Universal Job Match programme and complete three job applications on the system each session. A project worker gave an example of a client who was for applying for more than the number specified and another had inadvertently applied for a job as a dentist. Workers assisting their clients had also encountered problems with the Universal Job Match system when it has appeared to record a job application as completed although it has not been properly processed, and is therefore invalid.

Project workers also noted that many of their clients are initially panicked by the threat of losing their benefit but eventually became fatalistic. They reported clients saying that there is little point in trying to comply as they are convinced that they will not manage what they perceive as a very complicated process which is geared to make them fail. Workers reported their view that this had led to clients who were making good progress on all other fronts, reoffending to cope financially. Others had become so frustrated that they made a deliberate decision to offend in the hope of returning to prison, as this was the only way they could envisage coping. Sanctioning also resulted in loss of Housing Benefit and thereby rent arrears and potential homelessness.

Stress, anxiety, lowered self-esteem, reduced confidence and expectations were all seen as direct results of the changes in the welfare system. Sanctioning of benefits added physical health problems to the pot with poor or no nutrition and associated conditions of sleeping rough or homelessness.

Clients were seen to be so anxious about sanctioning that they often agreed to unrealistic conditions, leading them to fail in meeting the agreed conditions and getting sanctioned. Services present agreed that they were attending with clients to advocate on their behalf more frequently of late and that many clients were visibly ‘crumpling’ when interviewed by benefits staff.

In addition to the negative impact on clients, there was also the increased pressure on services and particularly third sector services, which were struggling to remain proactive in their delivery when their resources were being exhausted in fire-fighting. Services present said that they were now less able to support clients around their health needs as the concentration of their workload was in dealing with the impact of the welfare reforms.

“We try to get them back on their feet, but we are working against the tide these days.”

Money and somewhere to live were seen as the priorities for offenders, but it was pointed out that if someone is not emotionally well, work undertaken to support them with financial and accommodation issues needed to be ongoing as the client would not be able to maintain any progress made.
Offenders in the community appear to be unable to adequately manage their physical health as a priority because of their financial circumstances. The stress of their physical circumstances led to their emotional health suffering. Workers found the atmosphere and attitude of staff at the JobCentre to be demoralising and expressed concern that it must be doubly so for their clients.

The benefit-linked health assessment regime was also identified as a source of stress and anxiety for people. The assessments are conducted in Grimsby and this creates problems for clients living in North Lincolnshire as travel costs are reimbursed retrospectively, requiring the money to be found upfront by the client. The assessments were felt to be predominantly around physical capability and therefore failing to identify or consider mental health or learning disability. Workers reported that appeals are currently taking a year to process; meanwhile clients receive reduced rates of benefit which frequently results in declining health and reoffending.

Dual diagnosis was seen as an ongoing issue - “a ball that is still being batted around” - with examples given of clients told that they have a substance misuse issue by mental health personnel, but that they have a mental health issue by substance misuse specialists. It was recognised as difficult to treat mental health issues whilst someone was also involved in substance misuse, but that treatment to dual-diagnosis patients was not being implemented effectively locally.

One project worker gave an example of a service user they had known for a considerable number of years who had served several short prison sentences during this period. Although initially a mental health patient, as a result of escalating drug use, they were subsequently deemed to have behavioural problems rather than mental health issues. During a later period of incarceration a mental health disorder was diagnosed and they were released directly into Great Oaks.

Frustration was expressed by third sector service providers around the perception that local health services did not recognise them as 'fellow professionals' and were therefore unreceptive to their views about their clients’ needs. These workers felt that as they are often in contact with their clients on a daily if not hourly basis their views on how the clients is presenting should be sought and valued. In effect they felt that their experience and skill was being dismissed out of hand. Additional tensions were reported in the interaction between these third sector providers and the MH Crisis Team who, they felt, did not take support workers’ concerns over a perceived crisis for an individual seriously. Concerns were expressed that the criteria for a “crisis” were obscure and limited and there did not seem to be any intervention available before a crisis was reached.

Third sector providers reported feeling frustrated at the lack of guidance on how to handle a situation where they are presented with someone they view as “in crisis2 but that the mental health provider dismisses as not a crisis. This was found to be especially acute for projects where the worker is unable to leave the premises. It was also felt that a client’s offending history impacted on the level of service they received from Mental Health and there was a view expressed that some clients were “red-flagged”.
4.4. Resettlement

i. Literature Review

Key Documents Reviewed:

- **(On the Outside)** On the Outside Continuity of Care for people leaving prison - Sainsbury’s Centre for Mental Health 2008 (Keil et al)
- **(Bradley)** Bradley Report - Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system, April 2009
- **(Merseyside HNA)** Health needs assessment of adult offenders across the criminal justice system on Merseyside, June 2012 - Cath. Lewis and Alex Scott-Samuel, Liverpool Public Health Observatory

Introduction

As of May 31, 2013 there were 83,897 men, women and children in prisons and young offender institutions in England and Wales. The most recent set of quarterly statistics, which covers the period to 31 March 2013, shows that 10,768 men, women and children are held on remand in prison and 7,004 people are serving short sentences (below 12 months). Between October and December 2012 26,278 people in total were sent to prison. Of this number, 11,794 people were sent to prison to serve short sentences (less than 12 months)\(^{82}\).

In 2011, 54,837 people were remanded in custody, awaiting trial. In the same year, 39,391 people were remanded in prison, convicted, but awaiting sentence; 11,500 of those remanded in custody were subsequently acquitted, whilst 15,000 people remanded in custody went on to be given a non-custodial sentence. In the same year 85,540 prisoners were released from determinate sentences\(^{83}\).

**Key prisoner population characteristics:**

- 47% of male sentenced prisoners and 50% of female sentenced prisoners had run away from home when a child. This compares to 10% of the general population.
- Over 25% of prisoners had been taken into care as a child compared to 2% of the general population.
- 43% of prisoners had a family member that had been convicted of a criminal offence. 35% had a family member that had actually been in prison.
- 81% of prisoners were unmarried prior to imprisonment, rising to 85% since imprisonment. Almost 10% had been divorced. These figures are twice as high as those found in the general population.
- One-quarter of young male offenders in prison are young fathers.
- One in five women prisoners were living at home with dependent children at the time of imprisonment.
- One-half of male and one-third of female sentenced prisoners were excluded from school. One-half of male and seven out of ten female prisoners have no qualifications.
- Two-thirds of prisoners have numeracy skills at or below the level expected of an 11 year old. One-half have a reading disability and 82% have writing ability at, or below, this level.

\(^{82}\) Howard League for Penal Reform - Latest prison population figures week ending Friday 31 May 2013

\(^{83}\) Bromley Briefings Prison Factfile, The Prison Reform Trust - June 2012
- Two-thirds of prisoners were unemployed in the four weeks before imprisonment.
- Around 70% of prisoners suffer from two or more mental disorders. In the general population the figures are 5% for men and 2% for women.
- Prisoners are more likely to be abusers of illegal drugs and alcohol than other sectors of the community.
- Nearly three-quarters of prisoners were in receipt of benefits immediately before entering prison.
- 5% of prisoners were sleeping rough and almost one-third were not living in permanent accommodation prior to imprisonment.

Recently released prisoners are at a higher risk of suicide. From a cohort of 244,988 released prisoners, 382 suicides were identified within one year of release. Seventy-nine (21%) suicides took place within the first 28 days of release and 195 (51%) within the first 4 months. In comparison to the general population, recently released male prisoners were eight times, and women 36 times, more likely to die by suicide within one year of release from prison (Pratt D, Piper M, Appleby L, Webb R, Shaw J. 2006).

Remand prisoners have a range of mental health problems. More than three-quarters of men on remand suffer from a personality disorder. One in ten has a functional psychosis and more than half experience depression. For women on remand, nearly two-thirds suffer from depression. Freeman, G.K. et al (2002) found that these figures were higher than for sentenced prisoners.

**Resettlement responsibilities**

The Prison Service and the National Probation Service are responsible for an offender’s resettlement plan and local authorities have a statutory duty to assess and provide for an individual’s need for services identified in the resettlement plan. If, during the assessment process, it appears to the local authority that there may be a need for the provision of health or housing services, the local authority has a responsibility to notify the relevant PCT (as was - now Clinical Commissioning Groups, from 31 March 2012) or housing department and require it to assist in the making of the assessment.

‘Continuity of care’ is defined as: where people experience a coordinated and smooth progression of care through the health care system (Freeman, et al, 2002).

The Prison Service guidance of transfer and discharge of prisoners states that:

- Where a prisoner has a significant mental health problem and does not already have a community-based care coordinator, then a referral to a local community mental health team (CMHT) must be made.
- If a prisoner is not registered with a GP in the community, then the prison health care service must help the prisoner register with one before release.
- Follow-up appointments for secondary care services should be arranged for the prisoner where appropriate.
- Prisoners should be supplied with an appropriate supply of medication for release and the prison should assist them with completing a prescription exemption form.
- Prisoners should be provided with contact details for local services such as: GP surgeries, walk-in centres, drug agencies, Samaritans and NHS Direct (now defunct).
- Elderly prisoners, or those with disabilities who may need to have a community care assessment by the Social Services Department, should be referred appropriately.

---

84 www.parliament.uk/briefing-papers/sn04334.pdf
85 Suicide in recently released prisoners: a population-based cohort study. Lancet, 368: 119-123.
Health Assessments in Prison
Short-sentence prisoners are often not in prison long enough (over 12 months) to have their health needs assessed or to access any programmes or services to deal with identified health issues. Of course, these tend to be the ‘revolving-door’ clients (i.e. those who keep returning to custody). The ‘On the Outside’ report noted ‘Pre-release needs’ assessments are essential to maintaining continuity of care on release. If needs are not assessed while the prisoner is still in custody, the appropriate services cannot be expected to be available when they are released. This will either result in a delay in service provision or it could mean services are never actually provided. A thorough needs’ assessment, carried out in prison, will help to ensure the appropriate service is in place when the prisoner is released.

High numbers of the female prisoners interviewed for the ‘On the Outside’ study, reported mental health problems - in particular, depression and anxiety. It was also found that male prisoners were reluctant to disclose any mental health issues in prison which could result in them not receiving the continuity of care and/or treatment they had previously been receiving in the community prior to imprisonment.

Continuity of Care
Bradley cites the 2007 Mental Health Thematic Report by HM Inspectorate of Prisons which found failings throughout the offender pathway in relation to continuity of care. One issue highlighted was that in some cases there is no involvement by patients in their resettlement planning, compounding compliance issues and access to appropriate services (pg. 133).

‘On the Outside’ found that few of the women they interviewed for their research had a clear idea of the medication they were on. They observed that: ‘If the prisoners had more knowledge about their care or were more involved with the care they received, then they might be better placed to ensure the continuity of their own care upon release’ which would also mitigate the delays GPs may experience in gaining access to prisoner notes (On the Outside, 27).

Where people have been receiving treatment in prison, it is important to ensure that the engagement continues once they leave the prison gate. Feedback from stakeholders tells us that if prisoners get the support they need inside prisons they are more likely to engage with services outside prison. However, as most sentenced prisoners serve less than a year in custody they have limited time and opportunity to engage with prison programmes (Bradley, 112).

Resettlement Planning
The Big Diversion Project report (BDP) highlighted that resettlement planning was felt to go well when professionals from community agencies were encouraged to come into the prisons prior to release. This enabled the establishment of a relationship (or the re-establishment of an existing relationship) whilst their client was in custody. This meant that they were able to meet the prison mental health staff and start preparations within the community into which the prisoner was to be released, thus facilitating a smooth handover of care. Long distances, however, still posed problems for staff in undertaking face-to-face meetings for pre-release planning, as did prison security rules, which allow only three visits into the main body of the prison, as requested further visits necessitated a lengthy prison security clearance system.

Engaging with prisoners prior to release was also identified in ‘On the Outside’ as benefiting both prisoner and providers by starting to build up rapport. Moreover, the care
providers have the opportunity to interact with clients whilst they are relatively stable in that they are not using drugs and are having their day-to-day health needs met whilst in prison. On the other hand, when prisoners are pre-occupied with sorting housing and finances out on release, care providers are less likely to follow-up referrals for health-related needs, such as substance misuse.

**Mental Health**

The Care Programme Approach (CPA) was developed to ensure co-ordination and continuity of care for people with mental health problems. The 1991 report ‘The Future Organisation of Prison Health Care’ recommended that the NHS take responsibility for health services in prison, and that the CPA should be implemented effectively within prisons. Bradley found that, nearly ten years on, this was still not the case and that barriers to the implementation of CPA identified by in-reach managers included:

- prisoners not having an address on release;
- problems liaising with external agencies;
- geographical distance between prison and planned area of release;
- prison bureaucracy; and,
- IT difficulties

In addition, managers in Prison Mental Health Teams participating in the BDP report recognised the importance of maintaining the pre-custody Care Programme Approach arrangements whilst in prison, but they reported that patients were frequently discharged from this arrangement at the time of their imprisonment by their Community Mental Health provider, (pg. 174).

Bradley noted that it had been widely reported that in-reach teams have faced difficulties in getting community mental health teams to engage with patients who are about to be released. He noted that additional concerns about the fluidity of the prison population and problems around information-sharing and confidentiality may make effective implementation and co-ordination of CPA problematic (pg. 110). Bradley went on to recommend that Prison mental health teams must link with liaison and diversion services to ensure that planning for continuity of care is in place prior to a prisoner’s release under the Care Programme Approach; and that improved continuity of care for prisoners subject to the Care Programme Approach should become a mandatory item in the standard NHS contract for mental health.

Both Criminal Justice Liaison and Diversion teams and prison mental health teams participating in the BDP research in the North East reported that they sometimes struggled to get clients accepted by Mental Health Trust services. Issues reported included:

- being bounced between different teams’;
- need to bypass the access function to refer into the community teams directly;
- wide catchment areas for most of the prisons so that prison teams often needed to work across different teams and different Mental Health Trusts and this also inhibited the development of relationships with relevant professionals in community teams;
- Trusts varied as to their models of community provision, their threshold for access to a service and their route into services.

Bradley made note of the national framework which sets out arrangements to ensure the continuity of care of clients involving the criminal justice integrated teams that deliver the Drugs Intervention Programmes (DIP): namely, those located in the community; the drugs teams based in prisons; offender managers and treatment providers.

After hearing from stakeholders in the review, he concluded, however, that the links between DIP and mental health services were simply not being made. He went on to
recommend that joint-care planning between mental health services and drug-and-alcohol services should take place for prisoners on release, thus recognising that, for work with offenders with dual diagnosis and complex needs to be effective, depends on better assessment and information-sharing between various agencies involved with an individual’s care. This integrated approach would, he maintained, generate a complete picture of their needs (pg. 116).

Bradley identified a key role for developed liaison and diversion services to liaise with prison mental health in-reach teams. This would ensure that planning for the continuity of care for prisoners would encompass all organisations involved in resettlement.

**Release Dates**

One of the most frequently identified and acute resettlement issues arising from the literature under review were the difficulties in planning for release when an actual release date was unknown.

Release preparation requires considerable planning to ensure that a co-ordinated package of care is in place - especially for those with significant on-going health needs. This planning was frequently hampered by a lack of warning about release dates; unexpected releases from court; dropped charges, or release on licence at short notice. “Mental Health Team Managers reported frantic calls to crisis teams requesting urgent visits to vulnerable clients whose release was imminent or had already happened”. Senior health stakeholders also reported the frustration felt by crisis teams when receiving such phone-calls. (BDP pg. 175)

The Merseyside HNA suggested that better liaison between community and prison staff in terms of discharge-planning and timely notification of discharge from prison would have the additional benefit of reducing the number of assessments offenders had to undertake. The report noted that good links were already in place between CARATS (Counselling, Assessment, Referral, Advice, and Through-care services) at prisons and court-based mental health liaison teams, but that links between hospitals and community treatment providers could be improved.

One issue connected with this lack of liaison was that different information about offender health was stored on different computer systems. If computer records could somehow be linked, containing information about offenders who were on specific packages, then health-care staff time would be saved in assessing offenders. Moreover, offenders would have to go through fewer assessments, and timelier, appropriate health care could then be provided.

**Accessing Health Information**

Bradley found health information systems were not nationally compatible, making it difficult for other organisations to access the information they need to support a resettling offender, and recommended that “...’Health, primary care trusts and strategic health authorities should work together to roll out integrated information systems to health services provided in all criminal justice settings. (pg. 148)

Transfer of prisoner health information on resettlement was also identified as an issue in East Sussex. It was suggested that pathways from prison to community are often poor. For example, prisoners can be prescribed medication, but have no way of continuing medication on release, either because they do not have a GP or because their records do not follow them. In general, the transfer of records was identified as ‘poor’. It was suggested by one respondent that offenders should have a letter to take with them on release to help them to access healthcare wherever they go. It was felt that this would
provide some continuity of care for a range of health issues. The chaotic lifestyles of offenders themselves were also noted as a cause of disruption to referrals and accessing treatment pathways. (East Sussex HNA pg. 10)

The Merseyside Offender HNA highlighted the use of the Community Prison Offender Passport in use at HMP Liverpool, which aims to address the health needs of offenders and promote continuity of care from prison to community, in line with the recommendations of the Bradley Report.

The passport was developed primarily to address the health needs of offenders serving sentences of less than 12 months who would not have support from Merseyside Probation Trust upon release. As part of the passport, information is collected by Community Prison Officers on a range of health needs. These range from health issues which are more prevalent among prisoners, including mental health problems and alcohol and drug issues, as well as other health issues, and expand to incorporate wider quasi-health needs which have been shown to have a great impact on an offender’s mental health that, in turn, may well impact on the likelihood of re-offending. These include: accommodation, employment/training needs, relationship status and, inevitably, financial situation.

Housing and housing support
Housing has a significant impact upon the health of offenders. Offenders are likely to lose accommodation whilst in prison and some accommodation immediately following discharge is not suitable to prevent reoffending. Offenders who have withdrawn from drugs whilst in prison tend to resettle better in stricter environments or where counselling/support is available upon release.

Nonetheless, offenders reported that in some bail hostels, where drugs are readily available, the environment made it harder for them to stay away from drugs/alcohol. Offenders with drug and alcohol problems were less likely to be able to access emergency housing provision, either because their chaotic lifestyles did not enable them to comply with appointments/opening times to access this provision, or that they had been banned as a result of previous behaviour. Some offenders reported they were deterred from accessing services in the community for fear that they may come into contact with people who would encourage them to start using drugs or alcohol again. (Merseyside HNA, pg. 32)

Women Offenders and Resettlement
This report also noted that women tend to serve shorter sentences, meaning that there was less time to get accommodation arranged before discharge. Besides this, serving a short sentence can have a huge impact on their health if they lose their housing whilst in prison. Implicit in this, was also a likely loss of residency of their children following release.

Resettlement for women was especially problematic as many women did not feel comfortable with using treatment agencies, probation and hostels where women were in the minority. Health-care staff felt that female offenders whose children were living with them may be inhibited from raising these concerns for fear that it may result in the children being taken away from them. A proportion of female offenders, who were also street workers, were sometimes reluctant to address health concerns for fear of getting into trouble with the police or their probation officer.

Health and Housing
The links between housing and health for offenders on resettlement are highlighted in ‘Inside Out’ with key issues identified being that:
- Offenders are more likely to use drink or drugs as a coping mechanism if they do not have somewhere to live.
- It is harder for offenders to access services without a permanent address which will disrupt any continuity in care they may have received in prison.
- An offender is less likely to maintain a tenancy if they have substance misuse of mental health issues and are not receiving support.
- Where prisoners are pre-occupied with sorting housing and finances out when they are released they are less likely to follow-up referrals for health-related needs such as substance misuse.

These findings support the anecdotal evidence from an offender interviewed for a local qualitative study of Heath and Homelessness in North Lincolnshire. “There’s more rough sleepers now than last time I was sleeping rough - it could be any number of things [causing the increase] - they come out of jail, nothing to do, back on the same old road - taking drugs to get you to sleep at night when you’re rough sleeping”. This research also highlighted that homeless people - and over a third of the participants interviewed for this study were indeed offenders - often neglect their health as dealing with their homelessness is their major preoccupation.

Arrangements for post-release housing were reported by many managers interviewed for the BDP report as being put in place at the last minute or for prisoners to be released without housing: “Even the location of an approved premise for a high-risk client might not be finalised until the day prior to release.” Whilst a significant problem in itself, the lack of planned housing was seen as a barrier to the continuity of mental health care: joint working between housing advice services and mental health teams was seen as required. Key issues identified were:

- Complexity and length of time taken up to arrange housing which is complicated further when release dates are unknown or put forward;
- Lack of provision for offenders not identified in ‘priority need’;
- Reluctance by housing-providers to house clients with mental health issues.

The BDP report also raises the importance of linking of stable housing with health engagement and with services: “The post-prison leaving – that’s where it is the most crucial - if someone’s leaving prison, worrying about whether they’re registered with a GP and have they got an appointment with a community psychiatric nurse are icing on the cake. I would worry - even giving them the right meds, if they haven’t got a cabinet to put that medicine in and a house around that cabinet - it’s pretty worrying. If they haven’t got their benefits sorted then…so on and so forth - they’re immediately in difficulty.” (pg. 178)

Furthermore, the needs of remand prisoners can be overlooked when considering resettlement. Remand prisoners receive no financial help from the Prison Service at the point of release. They are also not eligible for practical support with resettlement from the Probation Service, even though they can be held on remand for as long as 12 months.

**Supporting Offenders with Complex needs**

Bradley recognised that the needs of released prisoners are complex and almost always interlinked, involving issues such as: impact of mental health problems, or the ability to secure employment, or the finding of sustained accommodation. In summary, offenders

---

87 Health and Homelessness in North Lincolnshire, 2012 - Czabaniuk and Gavin-Allen
being resettled must have access to a range of services to tackle these issues; otherwise, there is an increased risk that they will re-offend.

Mentors can provide both direct assistance (e.g. helping to fill in job applications or locate appropriate housing) and indirect support (e.g. encouragement or acting as a positive role model). Bradley noted that there were a number of charitable organisations proactively engaging with offenders prior to release and connecting them with services on the outside, often including meeting them at the prison gates. Evaluations of mentoring programme indicate that the most effective are those where the mentor and beneficiary spend more time together and where the mentoring is only one of a number of supporting interventions that is available. Bradley recommended that a comprehensive mentoring programme for people leaving custody with mental health problems or learning disabilities and returning to the community should be established.

**Barriers to Accessing Services**

The issue of multiple appointments and assessments for offenders was identified frequently in the reviewed literature. ‘On the Outside’ found that prisoners with complex needs might have a large number of appointments to keep and this can cause a logistical problem for the released prisoner. This is made worse by services being ‘fragmented’ - not just by location - but also as a result of poor communication between services. Released prisoners may have appointments to see service providers in several different locations at times which are perhaps not well coordinated. This will force people to choose which appointments to attend and therefore which needs are met. (pg. 50). The report calls for key care coordinators to help released prisoners to navigate through the large number of agencies they need to access according to the prisoner’s own priorities.

The journey from prison back into the community was different for each prisoner. Some of the non-statutory organisations taking part said that providing a flexible service was an integral part of what they offered, and also suggested that, in contrast, statutory services had a ‘one-size-fits-all’ attitude to their provision. This was put down to a lack of facilities and their high volume of clients. Once a released prisoner has begun to use a service, continued engagement is vital; this can depend on the individual’s motivation to engage with (and on the flexibility and persistence of) the services in meeting needs.

Offenders and health care staff participating in the Merseyside HNA expressed the view that services were indeed in place, should offenders be willing and/or able to use them. It was noted that offenders were more likely to use services where they could access several services under ‘one roof’, or drop-in services that they were able to access immediately. As many offenders had chaotic lifestyles, and were required to attend a number of appointments, it was advantageous wherever these could be minimised. Health-care staff and offenders, particularly those with drug/alcohol problems, reported that they would be more likely to use services in the community if they were all located in one place.

The ‘Options’ service, which works on the principle of ‘bringing health care to the offender’, is based at South Knowsley Probation Centre. It is the only full GP practice which operates in a probation office. A dedicated social worker works alongside nurses and GPs, as well as trained health and social care navigators, who are skilled in dealing with housing and employment issues, as well as providing signposting to other agencies.

**Continuity of Care in the community**

Bradley cites the 2007 mental health thematic report by HM Inspectorate of Prisons which found failings throughout the offender pathway in relation to continuity of care. Notably, for the purposes of this review:
Individuals not being picked up within three months on release from prison, resulting in disruption in treatment regimes, re-referral and reassessment by community services, and subsequent deterioration in a person’s mental state;

- Poor compliance by patients with resettlement and treatment regimes, resulting in possible re-offending;
- In some cases, no involvement by patients in their resettlement planning, compounding compliance issues and access to appropriate services (pg. 133).

On the Outside also identified the following barriers to effective resettlement:

- Released prisoners with no fixed abode experience difficulties accessing services as local authorities are reluctant to take responsibility for homeless prisoners and therefore will not provide funding for the service required. (pg. 51)
- Prison resettlement teams do not necessarily know about services outside their own locality - this may impact on prisoners serving sentences outside of their own area.
- Some prisoners may want to resettle in a new area to keep them away from past influences in their old locality that might cause them to reoffend; local authorities may be unwilling to help to relocate ex-prisoners with multiple needs who will require funding.

Specific issues around mental health included:

- Prisoners with a diagnosis of personality disorder may not meet the mental health criteria for some services.
- Prisoners with lower-level mental health problems were not being picked up as the mental health screening tools used by the Prison Service only identified the most severe mental health problems.

Differences in referral pathways and communication links between statutory and non-statutory organisations were identified as problematic. A possible reason for this was the increased regulations by which statutory agencies must abide. The BDP report also found difficulties with clients falling through gaps between different services or failing to meet high service thresholds. In this respect, dual diagnosis and personality-disorder cases were highlighted as posing particular challenges.

Information sharing
There was consensus across the reviewed literature that communicating and sharing client information with other service providers immeasurably helps in the improvement of services and in meeting the requirements of multiple needs offenders. Bradley recognised that appropriate information-sharing was key to ensuring the continuity of care and delivery of services throughout the criminal justice system and on release back into the community. He also noted that there were issues relating to confidentiality and privacy; organisational and cultural differences, and legislative requirements and data security.

On the Outside found that that level of information shared between service providers varied, with some organisations having to rely solely on the information given to them by the client, which may be partial or inaccurate. The report suggested that the National Offender Management Service (NOMS) should take the lead in improving information-sharing between agencies.

Bradley wanted to see Criminal Justice Mental Health Teams established in order for them to link with community mental health services throughout the offender pathway. This would, he suggested, improve the flow of health information between the different stages
of the criminal justice process. These teams would be able to act as the central co-ordinating point for information, which means that other parties would always know where to go, and who to ask for appropriate information.

Bradley found that as data is not routinely collected in relation to offenders’ health needs at every stage of the criminal justice system, the full scale of need is difficult to assess in order to inform commissioning and instigate the planning of appropriate services. Therefore he recommended that a minimum dataset should be developed for collection by Criminal Justice Mental Health Teams, to provide improved information to assess need, plan and performance-manage services, and inform commissioning decisions. (Pg. 139)

Effective Partnership Working
On the outside found that the quality of relationships and information-sharing was reported to depend on individual good practice and good working relationships between individuals that facilitate good communication on many levels. Nonetheless, the study found communication problems and difficulties between organisations were common, with resistance from statutory agencies towards working with non-statutory agencies if no such formal relationship had been established. Furthermore, there was evidence that communication channels were one-sided, although the statutory agencies could benefit from the information gathered by voluntary organisations but those voluntary organisations reported that statutory agencies never asked for information from them. This identified the need for non-statutory agencies to promote their work and their role in resettlement of prisoners work more widely and to work closely with statutory agencies.

Women Offenders
Much of the literature reviewed supports the recommendations of the Corston Report in relation to Women Offenders: prison sentences should be reserved for genuinely serious offences and for cases where the female offender showed violent behaviour. In preference, community sentences would ensure the continuity of services received in the community, rather than being disrupted by a short period of imprisonment.

Vulnerable Groups
The BDP identified that links needed to be developed with local services for black and minority ethnic (BME) groups and that gender-specific, age-specific and BME-specific approaches all needed to be developed with a clear need for improved monitoring of service-access and outcomes with relation to gender and ethnicity. Another priority was the need to integrate mental health with other resettlement planning and improve responses to those with a learning disability, autism, dual diagnosis or personality disorder. In common with other areas, Merseyside also found that health care staff reported that addressing the health needs of offenders with learning difficulties and learning disabilities was a problematic area.

ii. Stakeholder Engagement

There are no prisons in North Lincolnshire, generally male prisoners are sent to HMP Hull, HMP Everthorpe or HMP Doncaster; and female prisoners to HMP New Hall in West Yorkshire. All offenders sentenced to more than 12 months’ custody will have some period of licenced supervision by Humberside Probation Trust (HPT) on release and HPT chair and coordinate the Multi-Agency Public Protection Arrangements (MAPPA) panel.

Where a prisoner is already known to Probation they usually keep the same case manager who will visit them in prison. The Probation Trust report good communication with the prisons throughout the sentence, with consultation about licence conditions and the date
of release is always known. Accessing prisoners can be difficult for some agencies and the systems to do this seem to vary from prison to prison. The Probation Service do appear to have good access whereas other agencies with a role in resettlement had experienced problems obtaining passes in a timely manner to visit their clients.

Services involved in the resettlement of offenders reported finding obtaining information about a prisoner’s health needs on release as problematic:

‘It’s terrible trying to get any information from prison health care services; and through the gate healthcare is random in terms of linking up with services, we (Probation) have found that health professionals inside will talk to health professionals outside and bypass us. With regard to medication scripts that can be very important - if someone is having subutex when they have (undergo) a liver function test - quite critical bits (of information) can be missed out’

“We can’t get the information from the prisons about people’s hepatitis status as it’s classified information. So when people come out we don’t know whether they need their vaccinations or not. We can’t phone up the prison and ask ‘can you tell us someone’s hepatitis status, please, they were released yesterday, do we need to vaccinate them?’ Clients generally are able to tell us they have had their vaccinations, but we need evidence and if you can see evidence, you can save money on re-vaccinating. This is one of our KPIs and it is really frustrating when we have to try and justify why we have spent resources on re-vaccinating. It’s down to resources, you end up with staff spending time chasing people…”

Neither does it appear - despite the well documented high prevalence rates of suicide for prisoners within the first few weeks of release - that services are alerted if a prisoner had given cause for concern whilst in custody of suicide risk. Historical anecdotal evidence was given of an instance where a young man was released from prison and committed suicide several days later, it was discovered that he had on a number of occasions presented as a suicide risk in prison but this information was not relayed to the local CPN.

The Prison Service guidance of transfer and discharge of prisoners states that Prisoners should be supplied with an appropriate supply of medication for release. However, the equitable access centre in Scunthorpe reported instances when this was not apparent:

“Not in my experience - they come in having got no medication - saying they have no medication - there is no hand-off between us and the prison health services. In most cases if it’s a physical illness there is no problem with us giving a short supply of the medication whilst we wait for the notes - we are open Saturdays and it’s very difficult getting information from a prison on a Saturday. Drugs of misuse are frequently requested and we are fully aware that the prison medical staff may well have detoxed them from this medication. We can face some very challenging situations where a GP refuses to give them something that they are not happy to prescribe without medical evidence.”

In prison an offender’s compliance with a health or medication regime is generally good as it is managed for them. When they leave prison they have other priorities and compliance can slip. This can lead to health complications and without access to comprehensive information from prison health care this can lead to inequity of service:

“Thorough information gives you the opportunity to look at their needs in greater detail - don’t think it does patients any favours not sharing records as you end up with sticking plaster solutions as you don’t have the background.”
The information recorded on a prisoner’s OASys record by Probation is transferred into prison and is refreshed during the sentence. However, Probation staff reported the quality of the information can vary, but where the risk to be managed is high more detailed information is received on release.

If a prisoner has been identified as having social care needs upon resettlement Adult Social Services will attend the prison to carry out a social care assessment to put together a package of social care for the offender back in the community. Services report differences of opinion regarding need and diagnosis from that of prison health and social care providers. This was thought to be as a result of prisoners presenting as in greater need whilst in prison.

Adult Services reported that they will link with Probation regarding sourcing accommodation especially when considering physical disability. With the introduction of individual budgets for social care service users, Adult Services no longer provides the type packages of care it once did. Social workers report that this causes misunderstanding and frustration in the multi-agency setting, particularly MAPPA where there is an expectation that Adult Services will deliver a specific package of care:

“There have been occasions at meetings where we have carried out an assessment and laid out what we can provide and our eligibility criteria; but the Police have a perception and expectation as to what they (the offender) should have and that we are going to provide it. For example; it might be that somebody can’t go within a mile radius of a particular property - the expectation is that we will monitor that and we can’t.”

Mental Health Services also reported issues with the assessment and treatment of mental health conditions in prison; where assessments may be carried out without any reference to the offender’s previous diagnosis and treatment history.

“… visiting consultants will go into prison and make a diagnosis without any reference to local services so they don’t get the historical information - so where we may have diagnosed a personality disorder they may diagnose a psychosis of some description because they are basing it on what they see at the time - they don’t get the collateral evidence and information.”

The treatment pathways for psychosis are different those for someone with a personality disorder. Care Coordinators may find that someone they have been treating for a personality disorder in the community has been re-diagnosed with bipolar affective disorder in prison, which will have an impact on their continuity of care.

In North Lincolnshire, DIP will link with Counselling, Advice, Referral, Assessment and Throughcare (CARAT) teams in prison to offer release planning and community support to offenders including referrals into maintenance prescribing following a custodial sentence. This is critical to ensure continuity of care and safe prescribing.

Many offenders must link with substance misuse services as a condition of their licence. Usually six to eight weeks before a person is released, DIP receive a referral from the CARATS team. They are then allocated a case worker who will liaise with the prison and if practicable visit the prisoner prior to release. In recognition that the initial period after release is very high risk for offenders with substance misuse issues the DIP worker will meet the offender at the Prison on release and accompany them back to North
Lincolnshire. In these circumstances DIP usually receive a full history for substance misuse however for other health issues this is not always the case…

“Medically, it’s not always good as within the prison there are different departments dealing with different needs. So we can only go on what the client declares especially around Blood Borne Viruses, so from a health perspective that’s quite important. So there is a gap there, but I know that is being looked into over in Hull.”

Accommodation and Housing Related Support
It is common for offenders to lose their accommodation whilst in custody and there is a paucity of suitable supported accommodation for offenders in North Lincolnshire. All the stakeholders involved in resettlement worked very hard to try and secure appropriate accommodation for offenders, who meet their criteria for services, to give them a fighting chance of effective re-integration. However, offenders released on remand or who are not under the supervision of Probation have very little support when they return to their community. If they have lost their accommodation whilst in custody their only recourse is to approach the council’s Housing Advice Team, however if they are not identified as in priority need there is no statutory duty to house them but they will be given housing advice.

Humbercare, as the housing related support provider for offenders on resettlement, will carry out an assessment and develop a support plan based around the seven outcomes of the framework for resettlement with an offender referred in their service. Clients are usually referred through Probation, the Bail Hostel, Drug and Alcohol Services and Resettlement Teams. However, it is not uncommon for offenders to self-refer.

“The offender is released - they get their grant and that’s it they arrive back here - often it’s the client that telephones us when they are due for release. Or clients will write to us (from prison) - because they feel no one’s done anything for them especially if they’re not going to have any contact with probation post-release.”

If an offender is a client of Humbercare and they are sentenced to imprisonment of 12 weeks or less, Humbercare will support them to maintain their tenancy by completing the Housing Benefit paperwork and liaising with their landlord. This is critical as losing their accommodation would have a detrimental impact on their health and wellbeing outcomes and their likelihood of reoffending. If a person is remanded in prison and they are in receipt of Housing Benefit, the benefit will continue to be paid for up to 52 weeks. However, once they are sentenced, the housing benefit stops. If the offender has no other means of paying their rent this can lead to eviction. In these circumstances North Lincolnshire Homes will encourage them to terminate their tenancy. This is to avoid arrears building up which would ultimately lead to an eviction notice being served on that individual. A previous tenant with rent arrears where little or no payments have been made to reduce the debt or a previous eviction from North Lincolnshire Homes’ property renders a person ineligible for a place on their waiting list.

Accessing money and accommodation are the priorities for prisoners on release. Remand prisoners do not receive any financial support on release and sentenced prisoners receive a grant of £46.75 (this amount has not changed since 1997). If a person is released on a Friday afternoon it will be difficult to return to the area in time to make a benefit claim until the following Monday. New claimants are advised that a claim takes a minimum of 15 working days for a decision on eligibility for the benefit applied for - this may be a positive or negative decision and will depend on the accuracy and clarity of information and sufficiency and appropriateness of evidence provided by the claimant. . The usual
recourse for newly released offenders is to request an emergency loan until such time as they are in receipt of benefits, from the social fund, which then places the offender immediately in debt and having to live on reduced income whilst the debt is repaid at source.

North Lincolnshire Council's housing service works closely with local private landlords, through the Landlord Accreditation Scheme, to raise the standard of private rented accommodation in North Lincolnshire and to ensure that landlords and tenants are aware of their responsibilities to each other. Currently there are 30 members signed up to the voluntary scheme, some of whom are letting agents or landlords with several properties. However, there are also number of local private landlords who provide accommodation for those without references and deposits at short notice. This accommodation is generally of poor quality and shared with several other individuals in similar limited circumstances.

Humberside Probation Trust chairs and coordinates Multi Agency Public Probation Arrangements in North Lincolnshire. There are three levels of risk to MAPPA, some offenders can be MAPPA managed by one agency if they present a low risk. RDASH represent North Lincolnshire and Goole NHS Trust and the Clinical Commissioning Group on MAPPA and must feedback through these channels to ensure actions are implemented.

The view of participants at the stakeholder event was that MAPPA worked well generally in North Lincolnshire with agencies taking a holistic approach to the management of the offender. However there was a view expressed that ‘health’ providers were not as involved in the joint approach as other stakeholders would like.

4.5. Stakeholder Engagement on Key Vulnerable Groups

i. Women Offenders

Stakeholders identified a number of aspects of services for women offenders that they felt were working well. These included examples of good interagency working through the Women Offenders Forum, the identification of substance use in custody and onward referral to substance misuse services; and robust community support from non-statutory agencies such as Humbercare.

It was reported that female detainees in Police Custody are asked about pregnancy as part of the risk assessment process and given the opportunity to speak to a female member of staff if they wish to. Police interviewees expressed concern that there was a gap in provision for young females with mental health issues, whose behaviour had resulted in their detention, but where a CJS may not be appropriate for them and where the options for diversion and support were very limited.

Stakeholders identified sexual health advice as a specific issue for female offenders who are sex workers. Women referred into Substance Misuse Services are offered safer sex and harm reduction advice with a focus on ensuring the women are risk and safety aware. Pregnant female offenders with substance misuse issues are referred into the Specialist Midwifery service. However, it is unclear whether sex workers who are not on the substance misuse offender pathways have their sexual health needs fully assessed or met.

Humberside Probation Trust has established a Women’s Group in North Lincolnshire based in Scunthorpe and Barton upon Humber, running once a week. Two Offender Managers are on site and they manage all female service users within North Lincolnshire. Female
offenders are managed solely by female Offender Managers, and can access support from a variety of agencies that facilitate specific sessions for women. Workers from CYPS are also in attendance at the groups, so that any safeguarding issues can be dealt with in a timely manner.

There is a range of sessions that women offenders are able to access which are aimed at reducing their risk of reoffending and harm, including:

- Alcohol and Drug Awareness
- Self Esteem and Confidence Building
- Driving Awareness
- Domestic Abuse Awareness (inc. The Freedom Programme)
- Budgeting and Welfare Rights
- Employment

Women’s Groups activities are also available to those females who may be at bail stage and waiting to go to court, in order to start the process of supporting them, and this facility is also available to the families of offenders who may be serving a custodial sentence and have no other means of support.

Probation staff recognise there is an increased risk of suicide for people who are remanded in custody - particularly women. Probation reported making additional efforts to develop suitable bail and community sentence packages that keep women offenders in the community. Identifying health issues and meeting health needs is included in that process, however, it was acknowledged that the problem comes with finding the specialist health support they would need to access. Within drug treatment services locally a majority of the staff are female and this enables a more gender specific approach for most female offenders with a drug misuse problem.

An area for which stakeholders felt improvements were required was in better working relationships with mental health services. Stakeholders expressed their concern that inconsistent and ineffective data recording across all offender pathways impacted particularly on the health and wellbeing needs of women offenders.

The lack of forensic services was also reported as problematic; and the need identified for greater opportunities for health interventions for women whilst in police custody, with clear multi-agency pathways to avoid women offenders re-appearing in custody.

A nationally acknowledged issue for women offenders is the distance from their home location to a women’s prison, which impacts on the ability of family and friends to maintain contact - a proven benefit to rehabilitation, and North Lincolnshire is no different.

One of the most problematic areas reported by stakeholders for the resettlement of women offenders is their ability to find suitable accommodation, especially if they are seeking custody of children. Home Choice Lincs assesses an individual’s ability to afford a property. A potential tenant who is about to be released or resettled into the community from custody, is most likely to be a recipient of government benefits. The new restrictions recently applied to Housing Benefit apply a ceiling for payments based on the number of bedrooms required by that household based on their current circumstances. An offender, on release from custody would not immediately have their children with them and may have to spend some time seeking or regaining custody. The only property that would be financially viable for them would be a one-bedroom property, and this would then impact on their ability to gain custody as they would not be able to demonstrate their ability to provide an appropriate home for their children. This revision of the
benefits system impacts most frequently on women offenders, who then experience additional stress, anxiety and depression as a result.

Housing providers reported difficulties in engaging with Children and Young People’s Service (CYPS) to ascertain the likelihood of reuniting the family. Housing Related Support workers confirmed that regaining custody of children is a huge preoccupation for resettling women offenders and a major contributor to stress and anxiety. Better communication between Children’s Services and housing providers would help to mitigate this.

Stakeholders noted that whilst there was much good practice and intent, there was no single point of contact for women offenders with integrated services and teams, specialising in women offender’s issues and needs.

ii. Offenders from BME Backgrounds

Most of the stakeholders involved in the study were not aware of any specific health issues relating to BME offenders other than the linguistic barriers to access and the stigma of mental health or substance misuse in some communities. Stakeholders recognise that the BME offender population is growing and that shrinking budgets and a lack of staff expertise in this area are challenging for North Lincolnshire.

Stakeholders identified a number of aspects of services for BME offenders that they felt were working well. The Language Line is easily accessible, there are specialist services with a good understanding of BME clients’ needs including drop-in access to support at Cole Street operated by North Lincolnshire Homes - which is also open on Saturday mornings) and the South Humber Racial Equality Centre (SHREC).

Where a detainee in Police Custody is found to have linguistic needs the Police have access to Language Line and will also identify and provide for any dietary, religious or cultural needs such as access to a prayer room.

Probation staff have received training around BME/cultural issues and have a Single Equality Scheme gate keeping process whereby all prepared assessment reports have to be checked by a senior colleague to ensure that cultural issues have been considered.

However, providing appropriate support once issues have been identified has proven more difficult. Translation and interpretation services are available to a degree, but these are considered to be inadequate if the information is complicated or particularly technical, with a concern expressed that sometimes ‘important issues get lost in translation’.

Translations and interpretation resources are limited and many of the programmes and courses for offenders provided by Probation and other services are not accessible for non-English speaking offenders. This has led to inequity as BME offenders have missed out on opportunities to address their offending behaviour and have been processed through the CJS system. This has been a particular issue in North Lincolnshire with migrant workers who commit speeding offences – they cannot access the Driver Speed Awareness course as an alternative to having points on their licence, this affects insurance premiums and can result in disqualification if sufficient points are obtained. It is understood that the Probation Service is in the process of developing accessible alternatives to some courses for non-English speaking offenders.
Other agencies also reported that engaging with services is problematic for offenders from BME backgrounds and that capacity to meet linguistic and cultural needs is under-resourced.

Language and literacy were also identified as key barriers by other agencies. Anecdotal evidence was provided of missed appointments due to clients not understanding appointment details, translation or interpretation not being available or the client fearing that it would not be available. This was reported as a particular issue for substance misuse and mental health conditions, as clients were sometimes unwilling to ask for family or friends to assist in translation due to a cultural stigma associated with such conditions.

Stakeholders reported substantial differences within different ethnic communities in terms of the level of stigma associated with different types of offending or health issues and the availability of family or community support to aid recovery or resettlement. This in turn impacted on an offender’s ability to fully engage with, or benefit from, services.

Support for BME offenders out in the community can be problematic and there were examples of job seekers being expected to sign documents on the spot at the Job Centre without the opportunity to get them translated. There was a concern that Universal Job Match placed people who do not have sufficient understanding of English, those with poor literacy or learning difficulties and those with limited or no computer skills at a significant disadvantage.

Take up of mental health services by BME populations in North Lincolnshire is disproportionately low, which was attributed to the stigma of mental illness in some of these communities, this in turn can lead to mental health issues not being identified until the condition is exacerbated or as evidenced elsewhere in the research, until they enter the CJS.

“Engaging with BME populations is challenging - it is getting better - but we probably only see the most severe cases - as their mental health problems would have got worse over time”.

iii. Offenders with Mental Health Problems

Stakeholders identified the Probation Signposting packs, the Talking Shop (although this was felt to need a wider roll-out) and MAPPA as services for offenders with mental health problems as working well. It was reported that joint working between mental health and the Police had reduced the numbers of people being detained under Section 136 of the Mental Health Act; and Primary care mental health services provide access to a weekly mental health and wellbeing session every week in the probation hostel for offenders which was well received.

However, a significant proportion of stakeholders participating in the study expressed concern at the provision of services for offenders presenting with mental health needs. They reported frustration in engaging with mental health services particularly in relation to dealing with offenders in crisis and with obtaining mental health services’ ‘buy-in’ for integrated and partnership working initiatives.

Mental Health Services were concerned that they were often expected to provide treatment of services that they were not commissioned to provide and this had led to tensions with other services.
The most significant gap in services identified by stakeholders was the lack of specialist resources in North Lincolnshire to work with mentally disordered offenders whose offending behaviour is driven by their mental disorder.

The most significant gap in services identified by stakeholders was the lack of specialist resources in North Lincolnshire to work with mentally disordered offenders whose offending behaviour is driven by their mental disorder.

iv. Offenders with Learning Disabilities

The prevalence of Learning Disability amongst detainees entering police custody in North Lincolnshire is unknown. The Learning Disability Assessment Tool has been introduced for use by some services in initial contact with an offender and the OASYS used by Probation incorporates a skills checker. However, there was reported lack of awareness and support for offenders with learning disability and the tool was acknowledged as basic, with most services relying on an offender declaring or staff noticing a need.

Data from the Appropriate Adult (AA) service only reflects the numbers of referrals to that service, and the instances where a relative or friend acts as an AA is not captured in monitoring reports.

“We also ask questions like if offenders were statemented at school or what school they went to to provide insight – and may require us to do some more digging and adjust the methods by which we work with that offender. But we are not qualified to carry out a Learning Disability assessment”.

Most stakeholders felt that identification of need was dependent on the Learning Disability Team, but were unclear of the process or what happened following an assessment by them.

Also of concern was the prevalence of agencies who reported that assessment did not automatically result in eligibility for a service, and that clients were often deemed to not meet the criteria for specialist services. This, added to the frequency of ‘no-shows’ by clients who do not have the capacity to remember or find their way to appointments and were therefore ‘discharged’ from specialist services, added to the frustration felt by many stakeholders.

Areas which stakeholders felt improvements were required included the level and timeliness of information from prison, awareness of learning disability needs from health providers, the problems for offenders with learning disability around short sentences, and inappropriate or non-existent employment programmes in the area for offenders with or mental health problems.

v. Offenders with Dual Diagnosis

Stakeholders identified a number of areas in which they felt that services for offenders with dual diagnosis were currently working well. This included the belief that non-statutory agencies were doing an excellent job, with local agencies and staff being very resourceful and using their initiative in a very difficult area of work. The hospital-based place of safety was also seen as a positive.

Stakeholders reported a high incidence of personal disorder and drug issues amongst offenders on Drug Rehabilitation Requirement (DRR). This was seen to be a problem at
the court stage as it was difficult to get effective or suitable packages of support together to meet multiple needs.

Buy-in from mental health and learning disability services was reported as problematic; “we are left to do it, because we have to and we are left holding the baby to some extent....but we are ill met to meet their needs... when we get them here other services will withdraw their services.”

It was felt that an assessment for mental health in custody may not pick up a full history or patterns of behaviour for that individual. The fact that they are not currently using any substance but have in the past, may not be fully taken into consideration and therefore potential triggers for dual diagnosis may be missed.

Offenders with dual diagnosis were acknowledged by many stakeholders as the ‘unpopular patient’ for many services, and this resulted in poor customer service, inappropriate or non-existent levels of care and support, being barred from many (and sometimes all) services in an area.

“It can be a struggle to get people with multiple needs the most basic level of primary care - GPs are reluctant to take them on - even though we can offer to jointly manage their provision. If they can’t get a GP they can’t get a sick note, if they can’t get a sick note they can’t get benefits or accommodation and they present a very high risk of re-offending”.

“There have been instances when we have taken a case back to court as the offender is too mentally ill to deal with their drug issues and could not stick to the strictures of the DRR so they end up back in court.”

It’s a problem with dual diagnosis as well - “it’s not us because it’s alcohol, it’s not us because of this or that. Seems to be a case of sloping shoulders.”

5. Conclusions

In conclusion, throughout the literature review and stakeholder engagement, a number of clear themes have emerged.

5.1. Improving the efficiency and effectiveness of systems

The efficiency and effectiveness of systems proved to be a mixed bag for stakeholders, with some systems reportedly working well, whilst others proved to be inappropriate, non-existent or not used.

Researchers were told that information sharing and joint-working appeared to work well with agencies involved in MAPPA. However, those that did not link directly with MAPPA meetings were frustrated and often concerned especially when they were delivering intimate services to a MAPPA-managed offender but were not party to the risk management issues that offender presented.

“We have had information from the Bail hostel to say that there has been a MAPPA meeting and this is what the patient will need and you have nothing to worry about ... but
then the Risk Management PC will generally give us more information and he may say it would be helpful if the patient didn’t see a female clinician”...

“We need to be able to implement our own risk management - receive the information and form our own opinions rather than be told that this patient isn’t going to be a risk to anyone”.

The most frequently expressed concern around systems was the lack of understanding between agencies of their respective roles and criteria for services. This substantially undermined the smooth transfer of offenders through each stage of the care pathway.

Of particular concern was the inability to access information on what screening, results and subsequent treatment had been provided, especially around blood borne viruses, to offenders whilst in prison. This resulted in a breakdown of continuity of care, wasting resources and possibly endangering patients and their partners once released. Re-screening and treatment initiation had to be undertaken as a matter of course by outside agencies and this could interfere with progress of someone who was already partway through a treatment programme when they were released from prison.

The reliance on informal processes and good relationships rather than systems was a recurring theme, as was the frustration expressed around poor or non-existent information sharing between key agencies. The greatest level of concern appears to be around the dual diagnosis and treatment of offenders, who many felt were underserved and more frequently fell through the gaps in services.

The collection of data monitoring the health needs of offenders in police custody was proposed as a useful tool to inform commissioners of needs and trends, especially in view of the forthcoming transfer of health provision in Police custody to NHS England.

There was concern that the current standards of health care services and levels of forensic and specialist expertise present in police custody, may not be maintained on transfer to NHS England and this was felt to be vital to ensuring the quality of services required.

5.2. Working in partnership

The Police reported very effective partnership working with North Lincolnshire Homes, Safer Neighbourhoods, Probation and DIP. North Lincolnshire Homes were extremely enthusiastic at the level of their partnership working with Police in some of their localities and expressed their desire to see this employed across the whole of North Lincolnshire. The level of information and intelligence gleaned and available to Housing Officers was seen to be extremely beneficial in combating crime, reducing re-offending and raising health and wellbeing issues.

Engagement with health and social care providers was identified as difficult on occasions: “It’s across the board, if anyone isn’t going to turn up (to multi-agency meetings) it will be Children’s or Adult Services or Mental Health”. There was recognition that these tensions are more often than not as a result of agencies failing to appreciate each other’s service; “I don’t think collectively as agencies we have an understanding of the pathways - where we understand each other’s roles and are very clear about what we can do and what we can’t do”.

Some services were reported as reluctant to participate in new methods of working. An example was provided of a multi-agency information sharing agreement, which had been
circulated and signed up to by partners. However, one of the health agencies had stalled and there was a feeling that this was unlikely to be progressed. The problem was considered to be with the complex channels of bureaucracy within these organisations rather than at practitioner level.

There is significant bridge-building required between mental health services and other organisations involved in the offender pathway. Despite considerable investment in awareness-raising around mental health issues there is still a lack of understanding about roles and responsibilities of mental health service providers. The provision of dual diagnosis services seems to have further confused partners, indeed though these services sit within the same organisations there still appeared to be gaps in communication and understanding.

Information-sharing was seen as a way of enabling agencies to be more effective, efficient and responsive, more able to provide appropriate services and at the same time safeguard staff and clients.

The Safety Net system was seen as an effective tool, but needs to be used and acted upon consistently by all concerned.

The need to improve communication between prisons, Probation and other agencies concerned with offenders’ health history and needs was a recurring theme throughout the stakeholder engagement. More timely information on release dates to enable services to put the correct packages of care and support together was seen as key in supporting a smooth transition from prison to the community.

An electronic ‘Offender Health Passport’ similar to the model piloted in Merseyside, where a standardised document which acts a single point of information on an offender’s health and wellbeing etc was identified by several stakeholders. This complimented the proposal that where a resettling offender is registered with a GP, there should be a system in place to notify the GP of their release date and the treatment plan they have been following with recommendations for continuity of care.

5.3. Improving capacity and capability

Resources, capacity and training to improve capability were all reported as areas for concern especially with regard to keeping abreast of best practice.

“We are still playing catch up in terms of the aspirations in the Bradley report. We have tried as a Community Safety Partnership but it has been somewhat piecemeal - not been able to develop all singing all dancing diversion scheme with forensic mental health teams”

The most significant gap in services identified by stakeholders was the lack of specialist resources in North Lincolnshire to work with mentally disordered offenders whose offending behaviour is driven by their mental disorder, and planned commissioning of Liaison & Diversion Services provide an opportunity to meet this need.

The skills and expertise required to meet the health needs of detainees were recognised as unique. Drug trends are moving rapidly and the Police need access to the expertise to manage the associated risks posed to and by detainees in custody under the influence of such substances.
This echoed the request for a Forensic Nurse to be based in the Custody Suite. Such a professional could assess and flag issues around mental health, learning disability and dual diagnosis to provide to the court process in a more timely manner.

Stakeholders repeatedly identified the need for greater access to specialist expertise in mental health, learning disability and dual diagnosis across services. Training and awareness of health conditions particularity mental health and personality disorder was also identified as a need.

The Police reported having limited options for dealing with teen mental health issues and called for more training and pathways to help support these young people.

Police custody was recognised as a potential gateway into health services for some of the most hard to reach members of the community. Currently detainees are asked if they would like to see a drug or alcohol worker if they present with those issues. It was felt that better health outcomes could be achieved if drug treatment was a required element of detention, with a permanent health professional presence at the station.

Services were felt to be concentrated in Scunthorpe Town Centre and there was recognition that half of North Lincolnshire’s population lives in the smaller market towns and villages. The need for outreach services was therefore raised as a priority.

5.4. Equity of access to services

Securing suitable accommodation for a resettling offender is fundamental to increasing their chances of successful reintegration. There is a dearth of suitable accommodation locally to achieve this. However, an approach to mitigate this was raised by members of a focus group at North Lincolnshire Homes. It was suggested that where an existing tenant whose tenancy has been maintained well, is sent to prison and they terminate their tenancy - providing the crime was unrelated to their property or the immediate community - when due for release they could be given a priority on the waiting list and supported to complete a housing application in prison. North Lincolnshire Homes would be able to start working with them much sooner and put in place a robust tenancy action plan to reduce the problems and stress around release and resettlement. This would provide an added benefit in that the individual would move into secure and stable accommodation and the Police, Probation and other services would consistent contact point to improve monitoring and support.

Substantial hand-holding is required to achieve transition and “Assertive Linkage” rather than mere sign-posting was seen as an improvement for those clients who lacked capacity, understanding or the stamina required to ensure attendance at a range of appointments or compliance with set criteria. It was acknowledged that the third sector plays a crucial role in supporting offenders between the gaps in statutory provision. Better awareness, knowledge and acknowledgement of these skills and opportunities for engagement access was agreed to be essential.

Humberside Police no longer administer methadone to detainees in Police Custody. Detainees are therefore denied access to medication that they have been prescribed. This has resource implications for health service providers who have to reassess patients who have been in custody over the weekend and re-introduce their dosage of methadone safely. Concern was expressed that this move was not supported by clinical guidance - Drug dependence guidelines and local recovery systems.
5.5. Improving care pathways and continuity of care

The services that local agencies provide for offenders were recognised as impacting on their health and wellbeing, so the need for accurate information on health issues and needs was identified as essential. The need to improve the quality and detail of information available on offender’s health needs was seen as essential by all stakeholders.

Early recognition and treatment of dual diagnosis was felt to be a remedy for the ‘revolving door’ clients who enter prison, struggle with limited resources for appropriate interventions, return to the community with equally poor options for support and return to offending in a short period of time.

The lack of any formal, pro-active, preventative work with those with mental disorders to prevent them entering the CJS and to prevent behaviours becoming entrenched was of concern and stakeholders wanted to see Criminal Justice Liaison and Diversion activity within North Lincolnshire available as a priority.

Offenders need a solid, stable base to build from. Shared, unregulated and unsafe housing in the private sector undermines offenders’ ability to move forward and away from old behaviours. The Welfare Reforms add to the financial and emotional stresses experienced and undermine an offender’s ability to establish a healthy lifestyle, exacerbating existing conditions.

Without exception, improved quantity and quality of accommodation was raised as a priority by all stakeholders. Not only was this seen as a salve to reoffending but there was agreement that it could act as a preventative measure as well.

6. Recommendations

The following recommendations have been produced based on the national evidence from the literature review and local evidence from interviews and focus groups with stakeholders, as well as examples of best practice in improving the health and wellbeing of offenders.

1. Explore the opportunities for health promotion, engagement and intervention with all detainees in Police Custody.

2. Develop clear protocols for detainees in Police Custody who are escorted to Scunthorpe Accident & Emergency Departments so when they are discharged and returned to the custody suite they are accompanied with robust care plans, and that this protocol is applied consistently in all cases.

3. **NHS England to consider the** implications of denying detainees access to prescribed methadone in the custody suite, and explore options to mitigate impact on an offender’s treatment plan.

4. By 2014, responsibility for Offender Health in Police Custody will have transferred to the NHS and the Clinical Commissioning Group (CCG) will become responsible for commissioning appropriate services.

In readiness for this changeover, it is recommended that:
a. a comprehensive record of all health and wellbeing issues of offenders in Police custody and with Probation is collated and made available to the CCG, to include all instances of Substance use, Learning Disability, Mental Health and Dual Diagnosis, to better inform future commissioning,
b. the potential for using System One in the Police Custody suite be explored

5. In readiness for the availability of Criminal Justice Liaison and Diversion (CJLD) services being available in North Lincolnshire, collate all available information on the prevalence and learning disability, mental health and dual diagnosis to better inform the commissioning of appropriate CJLD services.

6. The Courts, Humberside Probation Service and RDASH to develop clear protocols/guidelines for the use of Mental Health Treatment Orders to ensure mentally disordered offenders in North Lincolnshire have access to this sentencing route where appropriate.

7. **NHS England to develop** a specification for the commissioning of specialist forensic mental health services, more closely aligned and integrated with other services across the offender pathways and responsive to local need.

8. “**MAPPA for everyone**” - Identify the key elements that make the MAPPA system of offender management successful, which could be rolled out and adopted across the offender pathway for less serious and/or repeat offenders, particularly resettling offenders who are not eligible for supervision by Probation.

9. The potential for developing and implementing a ‘Community Prison Offender Passport’ as used in Merseyside should be fully explored to aid the co-ordination of services involved in offender health and successful resettlement.

10. Develop and co-ordinate the agreement and circulation of clear protocols for each service concerned with offender health; to include health and wellbeing points of contact and advice at key locations in the offender health pathway.

11. Strengthen the links between, as well as within, the different agencies working with offenders, through joint training and regular dissemination of information on changes to services which must be cascaded across all levels of organisations effectively. Specifically:
   
   a. Joint awareness training with the Police and social care services around role and changes to the social care system
   b. Awareness training for all agencies around the roles and responsibilities of mental health service providers including criteria for accessing services for dual diagnosis and personality disordered offenders
   c. Broaden the delivery of Mental Health First Aid training to include all stakeholders involved in supporting offenders
   d. Development of a ‘lay person’s’ checklist to enable providers to identify at what point they should contact the Crisis Team and mental health services on behalf of their clients

12. Review the current use and impact of the SafetyNet system with a view to increasing its use and effectiveness.

13. Further develop the services available to women offenders and consider co-location or joint working to provide a ‘one-stop’ approach.
14. Map and co-ordinate those services available to offenders from BME backgrounds to expand knowledge and awareness among service providers and to provide a ‘one stop’ approach to include access to public health information and services.

15. Examine the potential for closer working between Children and Young People’s services and housing providers to better meet the accommodation needs of those offenders hoping to maintain or gain custody of their children on release from custody.

16. Increase the availability of information, advice and advocacy on the availability and eligibility for the full range of financial and physical support available to offenders.

In the course of drawing together the discrete elements of this study, it has become clear that professionals in North Lincolnshire fully acknowledge the importance of meeting the health and wellbeing needs of people who come into contact with the Criminal Justice System.

Improving health and wellbeing outcomes for offenders is in everybody's interest and therefore should be everybody’s business.

This can be effectively achieved only by fully integrating services for offenders, and those at risk of offending. This includes working closely with third-sector organisations that engage so effectively with their clients, often without due recognition.

A one-stop, person-centred, clear referral and outcome-focused approach to the health and wellbeing of offenders has the potential not only to improve health and well-being but also to reduce reoffending and the impact on acute services. However, this cannot succeed, without the full support of all services that engage with offenders and their genuine commitment to partnership working.

*   *   *   *   *

Finally, the authors would like to record their deep gratitude to all those organisations and individuals who gave their valuable time and insight to developing and conducting this study. Their willingness to share their experience, expertise and views has been invaluable.

Sally Czabaniuk and Jenny Gavin-Allen
Research and Engagement