Department of Health

Independent evaluation report of *Improving Health, Supporting Justice: A Consultation Document*

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

July 2008

DH INFORMATION READER BOX

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

Document purpose	For information
Gateway reference	10237
Title	Independent evaluation report of *Improving Health, Supporting Justice: A Consultation Document*
Author	Offender Health Research Network/Offender Health
Publication date	14 July 2008
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Director of Adult SSs, Special HA CEs, Directors of Commissioning/ Specialised Commissioning Groups, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Offender Health Leads and Criminal Justice Services
Circulation list	Voluntary organisations/NDPBs
Description	Independent evaluation of intergovernmental consultation document that focuses upon improving health and social care services for those individuals who have offended or are at risk of offending. Will form part of the evidence set for the developing national Offender Health and Social Care Strategy, likely to be published in spring 2009
Cross reference	*Improving Health, Supporting Justice: A Consultation Document* – gateway ref 9071
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	Offender Health Department of Health Wellington House London SE1 8UG (020) 7972 3919
For recipient's use	

Independent evaluation report of *Improving Health, Supporting Justice: A Consultation Document*

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

Charlotte Rennie and Amanda Roberts
Offender Health Research Network

July 2008

Contents

Acknowledgement

With thanks to Naomi Mwasambili, Jade Weston and David King for their assistance at the analysis stages; and to Dr Jane Senior and Professor Jenny Shaw for guidance throughout.

Glossary of abbreviations

A&E	accident and emergency
AHP	allied health professional
ASBO	Anti-Social Behaviour Order
BME	black and minority ethnic
CAF	Common Assessment Framework
CAMHS	child and adolescent mental health services
CDRP	Crime and Disorder Reduction Partnership
CJS	criminal justice system
CMHT	community mental health team
CPA	care programme approach
CPN	community psychiatric nurse
CPS	Crown Prosecution Service
CSIP	Care Services Improvement Partnership
CYPPB	Children and Young People's Partnership Board
DAAT	Drug and Alcohol Action Team
DCSF	Department for Children Schools and Families
DH	Department of Health
DIP	Drug Intervention Programme
ECM	Every Child Matters
GMC	General Medical Council
GP	general practitioner
HCC	Healthcare Commission
HIV	human immunodeficiency virus
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service

HSCCJ	health and social care in criminal justice
IDTS	Integrated Drug Treatment System
IT	information technology
JSNA	joint strategic needs assessment
KPI	key performance indicator
LA	local authority
LAA	Local Area Agreement
LCJB	Local Criminal Justice Board
LGBT	lesbian, gay, bisexual and transgender
LSP	Local Strategic Partnership
MAPPA	Multi-Agency Public Protection Arrangements
MDO	mentally disordered offender
MoJ	Ministry of Justice
NAT	National AIDS Trust
NHS	National Health Service
NIMHE	National Institute of Mental Health Executive
NOMS	National Offender Management Service
NSPIS	National Stratgy for Police Information Systems
OASys	Offender Assessment System
PALS	Patient Advice and Liaison Services
PCT	primary care trust
PPO	prolific and other priority offender
PSA	Public Service Agreement
QOF	Quality and Outcomes Framework
ROM	regional offender manager
SHA	strategic health authority

SPOC	single point of contact
STC	secure training centre
STI	sexually transmitted infection
TSO	third sector organisation
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
UNCRC	United Nations Convention on the Rights of the Child
VCS	voluntary and community sector
YJB	Youth Justice Board
YOI	young offender institution
YOS	Youth Offending Service
YOT	Youth Offending Team

Introduction

Collectively, the Department of Health, the Department for Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office have responsibility for health and social care services within the criminal justice system. The document *Improving Health, Supporting Justice – a consultation* forms the basis of a strategy to support the delivery of integrated, evidence-based services that are responsive to the complex and inextricably linked health and social care needs of people who have either committed a criminal offence or are suspected of committing a criminal offence.

'Improving the health and well-being of people in the criminal justice system is an important element of the reducing re-offending and health inequalities agendas … this consultation provides a real opportunity to be a part of taking this agenda forward'

Ivan Lewis,
Parliamentary under Secretary of State
for Care Services

It should be noted by the reader, that this report is an independent analysis of the responses to the consultation document *Improving Health, Supporting Justice* and is intended to form part of an evidence set to inform and advise the development of future strategy and policy. The Department of Health, Ministry of Justice, Home Office and the Department for Children, Schools and Families are in no way bound by this document. All views expressed in this analysis (apart from those specifically attributed) are those of public and professional respondents to the consultation and should not be taken as departmental policy or an indication of future commitment.

The consultation process

In partnership with the Ministry of Justice, the Home Office and the Department for Children, Schools and Families, the Department of Health developed the consultation document *Improving Health, Supporting Justice*. The consultation document was approved by a multi-agency, inter-departmental executive group. Membership of this group was drawn from the inter-governmental departments highlighted above, third sector organisations and practitioners from the field. Prior to publication of the consultation document, clearance was obtained from the Department of Health Gateway team, and ministerial approval granted via the Domestic Affairs Committee.

The consultation document was formally launched on 27 November 2007 at a joint Ministry of Justice and Department of Health event. Subsequently, nine regional events were held across England drawing representation from all key stakeholder groups. These events reported directly into the consultation process and had average attendances of approximately 100 people.

In addition the consultation document was sent directly to 140 key stakeholder groups, and 80 copies of the document were issued to each of the ten Health and Social Care in Criminal Justice (HSCCJ) leads providing regional support across England, for distribution to additional regional stakeholders. By the end of the consultation period, 2,100 paper copies of the consultation document had been distributed. The consultation documents were made available on the Department of Health website for downloading. No information is available as to the activity on the site and, therefore, on subsequent downloads.

The consultation formally ended on 4 March 2008, with the final return received on 28 March.

The consultation sought views on the proposed strategic direction in accordance with the Cabinet Office's Code of Practice on Consultation.

The consultation questionnaire consisted of 109 questions and requested responses in the following areas: communities and responsibilities; police, police custody and the Crown Prosecution Service; courts and sentencing; prisons and rehabilitation; probation, release and resettlement; commissioning; partnership working; provider development and support; information systems and management; service user involvement; workforce and training; governance and performance management; equality and diversity; capital and estate management; and general issues surrounding the delivery of the strategy.

Using the consultation responses to develop policy

This formal written consultation forms part of a process to develop a joint national strategy to address the health and social care needs of those individuals and their families who have offended or are at risk of offending. There is much evidence to indicate that many of these individuals are derived from the most socially excluded groups within society today. Because of this, a cross-governmental approach is being adopted to focus upon the needs of this group. Often, small changes made in one area of an individual's life, for example addressing housing needs, can have significantly beneficial effects upon their mental and physical health, their potential for obtaining employment, the maintenance of their relationships and their offending behaviour. Therefore it is the intention to circulate this analysis widely throughout the health, social care and criminal partners involved in developing the national strategy. This paper forms part of a much wider information and evidence-gathering exercise designed to inform the final publication of the national strategy. Each suggestion within this analysis will be formally evaluated by the team developing the national strategy and many elements, subject to detailed economic, equality and impact analysis, will be included as part of the strategy itself. Such analyses will be made available as part of a suite of documents published with the final strategy,

The final strategy will also set out the work programme for the Offender Health team within the Department of Health; a programme of policy development, service support and national innovation based, in part, upon the suggestions from this analysis.

In December 2007, Lord Bradley was asked by the Secretary of State for Justice to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services, review the barriers to such diversion and make recommendations to Government. It is likely that the Government's response to the Bradley review will form a significant part of the national strategy. This consultation analysis will be formally submitted to Lord Bradley as part of the evidence base for his review.

Where areas are identified as being specifically relevant, for example social care, direct contact with those areas will be made to ensure the view reflected in this analysis may be adequately represented.

Finally, all policy leads within Offender Health will be asked to review this analysis and identify what impacts its suggestions will have upon their current work programme. This will be a formal part of their business programme review.

Responses

One hundred and forty-two responses were received. Some respondents collaborated with other agencies to produce a single response; in total, 203 discrete agencies had input into the consultation. The responses were grouped as follows:

- two from academic institutions;
- five from the commercial sector;
- three from court services;
- five from prison establishments;
- 10 from probation services;
- 28 from third sector organisations and patient forums;
- 10 from professional bodies and trade unions;
- 21 from primary care trusts;
- nine from mental health trusts;
- eight from regional/strategic health authorities;
- eight from inspectorates;
- seven from local government organisations;
- three from the Ministry of Justice;
- five from opinion formers;
- four from other government departments;
- 10 from police services;
- one from a Local Criminal Justice Board/Crime and Disorder Reduction Partnership; and
- three from private individuals.

Appendix 1 shows the list of respondents, including collaborators.

Method of evaluation

Responses were analysed thematically on a question by question basis. Themes occurring most frequently were given a higher priority in the write up, that is, reported in the first paragraph. For responses not submitted in the suggested format every endeavour was made to ensure that responses were incorporated into the relevant sections of the consultation.

The consultation requested respondents to submit what they perceived to be specific and general examples of local good practice in the field. These are summarised in appendix 2. It is to be noted that the practice examples offered by respondents have not been verified by the authors of this report, nor by any of the government departments involved.

Additionally, journal articles and/or other documents referred to in respondents' replies are listed in appendix 3.

Confidentiality

The consultation document outlined that information provided would be published or disclosed in accordance with the Freedom of Information Act (2000), the Data Protection Act (1998) and the Environmental Information Regulations (2004). If anyone had expressed a desire for their response to remain anonymous this would have been considered by the consultations co-ordinator. However, no organisation requested such anonymity. In the practice examples any individuals' names and personal contact details submitted have been removed.

Results

Introduction – How we would like it to be

Vision

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

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

Improving Health, Supporting Justice asked a series of questions on this topic.

Question 1 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

On the whole, it was felt that the draft strategy and the principles and values underpinning it were a step in the right direction. Respondents welcomed the cross-governmental partnership and the opportunities this aims to provide for the mainstreaming of services. It was largely felt that implementation of the strategy, although correct in vision, would be challenging and, in order to achieve the majority of its aims, there will need to be promotion of multi-agency working within and between the criminal justice system (CJS) and health and social care agencies (Her Majesty's Inspectorate of Prisons, 2004; 2005; 2008). Agencies would need to be provided with the resources and training to enable this to be implemented. It was suggested from several agencies that, in order to achieve this, the Government should implement a 'duty to co-operate' clause in the final strategy.

Respondents felt that the strategy was unbalanced in that it focused heavily on health considerations to the detriment of social care provision. Several agencies suggested it should have focused more on crime prevention and early intervention measures. A series of priorities for the final strategy were suggested by three or more sectors; specifically, the need for more specific service provision to meet the needs of offenders with personality disorders, learning difficulties (McBrien et al., 2003) or dual (or multiple) diagnoses, children and young people, and people from black and minority ethnic backgrounds. Two respondents requested the urgent implementation of the recommendations made in the Corston Report (Home Office, 2007) for distinct service provision for women.

Additionally, but to a lesser extent, respondents suggested that the needs of the ageing prison population, families of offenders, and victims of crime needed to be addressed. The need for better integration of health and social services was stressed in relation to the provision of appropriate housing for female offenders and their children, and those in need of approved premises on release. Two agencies suggested the need to address the impact that a lack of employment has on offender health and resettlement post release.

Responses from single agencies suggested the strategy should address prisoner movement across the prison estate, due to a perceived detrimental impact on resettlement planning and continuity of aftercare. There was a call for the Department of Health's (DH) pilot initiative aimed at reducing delays in transferring mentally ill prisoners to hospital under mental health legislation to be rolled out nationally, and for the stigma attached to mentally disordered offenders (MDOs) to be addressed. There was also a single call for *offender health* to be regarded as indistinct from public health, and as a continuation of community care. One agency requested a clearer link to the DH and the National Institute of Mental Health Executive's (NIMHE) work on the prevention of violence and abuse.

Many agencies stated they had directed their responses about children and young people's services to the separate children's strategy. Of the responses received, it was suggested that there needed to be greater emphasis on young people's transition to adult services, to prevent young offenders from 'slipping through the net'. It was also suggested that the offender health strategy needed to be implemented within the context of the Every Child Matters (ECM) agenda, as well as being set within the rights-based framework of the United Nations Convention on the Rights of the Child (UNCRC) (United Nations, 1989). There was a call for more robust assessment not only of mental health needs, but also of educational needs, possibly highlighting learning difficulty and/or acquired brain injury. The importance of providing treatment programmes for adult sex offenders was stressed, to reduce risk of sexual harm to children. There was a call for the implementation of early intervention and preventive programmes for young people and adults misusing drugs and alcohol (Downes and Job, 2007).

Respondents feel that the success of the strategy would depend upon the workforce having the right skills and knowledge to achieve the aim of cross-agency partnership working. It was felt that multi-disciplinary training and a greater understanding of the roles and responsibilities of other sectors would facilitate this, and that Government should acknowledge this as a high priority for resource provision. This issue will be discussed in more detail in section 2. There were two responses supporting a Government commitment to increase the scope and activity of research to improve prison health.

Question 2 – Do you have any examples of good practice that can be cited in the main strategy or the Children and Young People's strategy?

See appendix 2 for practice examples.

Question 3 – Are there any significant areas which have been missed in this section?

The themes in question 3 were similar to those in question 1. There were two high priority areas. Firstly, more service provision is needed to meet the complex health care needs of older offenders in prison, and their health and social care needs upon re-integration into the community. Respondents stated this could be achieved by better resettlement planning, with increased availability of suitable housing and supported housing schemes. This enhanced service provision for the elderly was recommended in two regional responses, from three third sector organisations, two primary care trusts (PCTs) and two opinion formers, and in one response from the Ministry of Justice (MoJ).

Secondly, one PCT, two probation services, three third sector organisations and one local government body stated that services for those with learning difficulties were under-developed, across the age spectrum. It was proposed that the commissioning of research into the prevalence of learning difficulties and gaps in service provision was a first necessary step. One probation service stated that not only are the needs of people with learning difficulties not being met, they are specifically excluded from, for example, National Offender Management Service (NOMs) accredited cognitive behavioural therapy programmes that require an IQ of higher than 80. It was felt that this did not fit comfortably with legally sanctioned disability rights. It was also suggested in a local government response that there needed to be attention to the needs of those people from special education backgrounds falling outside the remit of learning difficulties services.

To a lesser extent, respondents felt that there was lack of appropriate housing for all offenders and that this needed to be a priority in commissioning. It was suggested that housing provision was inextricably connected to the health and well-being and future prospects of offenders.

Once again, it was felt that services for offenders with personality disorders and chronic and long-term illnesses, black and ethnic minorities and children and young people were not as developed as they should be.

Single respondents to this question suggested a need for:

- research to be directed towards offenders in the community as opposed to in the prison estate;
- social care and health to receive equal priority in the strategy;
- stigma and discrimination of mentally disordered offenders to be addressed;
- physical health and sexual health needs to be addressed while serving a sentence;
- the connection between diet/nutrition, substance misuse and mental ill-health to be researched;
- the needs of foreign nationals to be explored; and
- an exploration of the needs of those with dual (or multiple) diagnoses and those whose offending is driven by a combination of mental ill-health and a chaotic lifestyle.

Single responses specific to children and young people advocated:

- better and consistent screening;
- more support for families of offenders;
- a greater emphasis on preventive services for youth offenders in the community rather than in the secure estate;
- support for integrated services and joint working between services for children and adults and management of the pathways to care when moving from children's to adult services, with joint incentives and pooled funding to facilitate this; and
- a better strategic alignment with the context of the ECM agendas.

Question 4 – How could the outcomes/outputs of these deliverables be effectively measured?

Respondent agencies were unified in their view that if the aim of the strategy is to effect better partnership working between health and social care agencies providing services for offenders, then a set of shared standardised outcome measures across all organisations should follow. Suggestions of how to measure the outputs of these deliverables consisted of: service mapping against national benchmarks; using Local Criminal Justice Board (LCJB) targets; using the Public Service Agreement (PSA) structure; using local partnership structures such as the Crime and Disorder Reduction Partnerships (CDRPs); the utilisation of audit systems that measure performance delivery; using the Offender Assessment System (OASys); and utilising a national enhanced service model such as the Quality and Outcomes Framework (QOF).

Question 5 – How can organisations be better supported to work in partnership and integrate their planning and delivery of services, including through aligned commissioning?

Respondents suggested that in order to work in partnership and integrate planning and delivery of services, including through aligned commissioning, joint multi-agency training must be implemented. Additionally, there was a need for all staff to have an awareness of the differing organisational cultures of each stakeholder whereby an understanding of their roles, goals, targets and so on would facilitate more effective collaborative working. It was stated that the barriers between agencies needed breaking down, with a need for joined-up information technology systems to enable information sharing.

It was felt that a clear strategic direction and framework for aligned commissioning from the cross-governmental agencies was needed to guide this vision. It would need to provide joint targets and priorities, and implement joint funding streams to promote collaborative working. It was also noted that penalties should be enforced by government agencies for not achieving acceptable standards of partnership working. One response from a probation service requested that the government take account of local arrangements for partnerships, prioritisation, funding, performance and outcomes. One response from an academic institution requested that partnership boards be established within local health communities which had overall responsibility for engaging stakeholders in their area. Numerous third sector organisations requested that government acknowledge the important contributions that third sector organisations and patient forums made to the reducing re-offending agenda and to consider this contribution in the development of the final strategy.

Question 6 – How can we ensure that roles and responsibilities around offenders with mental health and/or substance misuse needs moving 'through the prison gate' are clearer, to prevent delays in accessing health services?

On the whole, respondents felt the answer to this question lay in more effective joined-up working practices and communication between health and social care agencies, and the development of an integrated care pathway 'through the gate'. It was felt that more effective collaboration between prisons and probation services would aid pre-release planning and therefore provide for a smoother re-integration into society. In order to help reduce delays for offenders in accessing health services it is felt that reception screening could be improved, as could diversion away from the criminal justice system, drug testing on arrest, less movement for prisoners around the prison estate, the provision of the Integrated Drug Treatment System (IDTS) across all prisons and clearer guidance on establishing responsible commissioners for health services for offenders.

Several respondents advocated new services, including piloting a responsible deputy governor for health in each prison category, the integration of in-reach into existing mental health services, and the development of specialist resettlement teams. The vast majority felt that in order for all this to be possible, the Government must consider the integration of information technology systems.

Question 7 – How can robust partnership work between health, social care, children's services and criminal justice agencies be promoted to ensure that targets and priorities are aligned more closely at regional and local level?

Overwhelmingly, respondents suggested that robust partnership working could be promoted primarily by a strong cohesive strategy and Government direction with 'duty-to-cooperate' clauses. Seven agencies suggested that Local Area Agreements (LAAs) were the most plausible solution. Other respondents suggested that PSAs could also facilitate this, together with guidance from NOMS. It was suggested that having one central agency lead would be beneficial. All respondents acknowledged the need for shared targets, priorities and aims, and better information sharing to break down barriers between agencies.

The need for joint training was a recurring theme, as was the need for agencies to have a better understanding of the roles and responsibilities of the partners they are expected to work together with. Joint training has been provided in the London area on issues such as mental health, substance misuse, risk, information exchange, and criminal justice issues, and London probation staff reported very positive feedback since the initiative.

Other suggestions comprised: regional and local steering groups; regional strategic boards with local implementation groups; and prison health partnership boards replicating the Drug and Alcohol Action Teams (DAATs) model. One agency suggested that while creating the vision of partnership working, care must be taken to ensure that services do not overlap; an example of this was given as the work of the Children and Young People's Partnership Board (CYPPB) and the Teenage Partnership Board for Youth Offending Services (YOS). There was also a single call for offender health to be incorporated into annual public health plans for every PCT.

Question 8 – How can organisations better support gender specific services across the CJS?

The predominant response was for implementation of recommendations made in the Corston Report (Home Office, 2007). Respondents suggested a need once again for cross-agency training, funding to implement services specific to women, and cross-agency information systems, both to facilitate sharing of information and to share the evidence-based knowledge of different agencies in the same locality, as women have multiple problems (Hamlyn and Lewis, 2000; Fawcett Society, 2001; Home Office, 2004; Gelsthorpe et al., 2007).

More than two agencies suggested that more support was needed for community-based women's centres providing a holistic service. Three specific examples of local practice were submitted (included in appendix 2).

Question 9 – How can organisations better support the integration of children in contact with the youth justice service into the wider Change for Children agenda, in relation both to access to universal services as well as to targeted preventive and early intervention services across health, education and social care?

Emergent themes were a need for more funding for community-based health and social care centres; stronger partnership working; more prevention programmes; and cross-agency training in schools in order to raise awareness of high-risk behaviours. Two responses suggested that there needs to be offender health representation on children's boards. Additionally, it was suggested by a single agency that:

- the introduction of the Common Assessment Framework (CAF) taken from the ECM agenda was essential. The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met;
- combined targets for health, social care and CJS agencies would foster improved service response and integration;
- the Department for Children, Schools and Families (DCSF) 'contact point' initiative should be widely adopted;
- the prominence of the Teenage Partnership Board and the CYPPB should increase to ensure that organisations give greater commitment to them; and
- the transition from YOS to adult probation supervision should be better facilitated.

Question 10 – How do we directly engage with offenders, to ensure our services are relevant and empowering?

The general consensus was that third sector organisations (TSOs) and patient user groups were best placed to engage with 'hard-to-reach' groups and to obtain genuinely honest feedback about services from offenders and their families. It was also suggested that there was a need for creative involvement with offenders, and that partnership working between TSOs and the statutory sector was needed to ensure that the in-depth knowledge of service users gathered by TSOs informed the development of services. Numerous respondents suggested that in order to facilitate this partnership working and information exchange between TSOs and other health and social care agencies, there needs to be an acknowledgement of the important work conducted by TSOs. Importantly, service users needed to feel that their involvement was meaningful and that services would change in response to their expressed needs.

A number of suggestions were made to improve engagement with offenders, including: addressing issues of stigma and discrimination associated with offenders and mentally disordered offenders; an increase in advocacy services; an expansion in services such as Patient Advice and Liaison Services (PALS) and listeners schemes both in prisons and in the community; and the provision of information for offenders and their families in a variety of formats such as 'easy read'.

Proposals were made for the strategy to consider service user representatives on partnership boards and that there should be service user consultations forums both in custodial and community settings, and that these should be integral to strategy development and service re-evaluation.

One respondent stated that this could be achieved by adopting the principles of 'Recovery'. It works 'on the out' and these people respond in the same way to an approach which respects their individuality and integrity and which promotes hope (Anthony, 1993; Shepherd et al., 2008).

Question 11 – How do we promote a vision for service provision in all health and social care communities but avoid being too prescriptive and preventing local communities designing their own approach?

Almost unanimously, respondents suggested that there was a need for an overarching framework, setting minimum standards and expectations from Government at a national level that should be largely prescriptive, but with local communities permitted to design services informed by local need and to then tender these services out. There were calls for concerned cross-governmental agencies to devise policy implementation guidance, i.e. a list of services that areas should provide generically, or a national toolkit that gave a guide structure that allowed each area to develop its own programmes. Respondents took the question a step further and suggested that this could be monitored by the Healthcare Commission (HCC) and HM Inspectorates, and also by the establishment of partnership boards, with full stakeholder representation, across relevant prison/probation areas to govern the local offender health agenda. One respondent agency stated that there was a need to 'prescribe' the right services, but with an emphasis on expected outcomes rather than precise models of service. Two responses, however, suggested that targets needed to be 'very loose' to encourage local developments.

Other comments

Several respondents stated that the draft strategy document was difficult to read and repetitive. They suggested that it needed to be simplified and considerably shortened. Two respondents suggested that the term '*offender*' should be changed to '*socially marginalised*'.

Other comments from single agencies included:

- more links are needed between other strategy documents in relation to identifying targets;
- it should not be assumed that there is a link between health and offending and more research is needed in this area;
- more early interventions are needed; and
- the vision assumes mainstream health services engage willingly, and that this was not always the case.

Section 1 – The opportunity for change

Part 1: Communities and responsibilities

Vision

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

Under this part heading, the following questions were posed.

Question 12 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

In general, respondents welcomed the priorities identified in this section, but some identified additional priorities. In particular, respondents felt that certain populations of offenders had not been represented within the strategy (see question 14).

Question 13 – Do you have any examples of good practice that can be cited in the main strategy or the Children and Young People's strategy?

See appendix 2 for practice examples.

Question 14 – Are there any significant areas which have been missed in this section?

The majority of respondents felt that the section was comprehensive. Some felt that there should have been more emphasis on certain groups, including: older prisoners; women; offenders with learning difficulty; those with Asperger's syndrome; those with sensory impairment; people with personality disorder; people with dual diagnosis; short sentence prisoners; young people (offenders and dependents of offenders); high-risk and sexual offenders; black and minority ethnic offenders; and homeless offenders.

Single responses suggested that gaps in existing service provision included:

- joint commissioning;
- better screening and assessment using the CAF;
- better system of general practitioner (GP) registration due to current low take-up (Halliday, 2007);
- provision of specific services for the groups outlined above;
- services for those with human immunodeficiency virus (HIV) and hepatitis;
- primary care service development;
- social care service development;
- services at the transition from child to adult services;
- art-based interventions;
- information technology (IT) provision;
- better through-care from prison to the community;
- staff training;

- independent sector provision of community-based services;
- resettlement needs in rural communities; and
- examination of housing needs.

Question 15 – How could the outcomes/outputs of these deliverables be effectively measured?

Respondents felt that the best ways the outcomes/outputs of these deliverables could be effectively measured were through national guidance; minimum standards; audits; information sharing; service mapping; face-to-face meetings; wide-ranging needs assessment; better quality of data (including data on percentage of offenders registered with a GP after CJS contact); service user involvement; and utilising care pathways, including measuring access to mental health services/mental health workers at key points such as point of arrest and court.

Question 16 – To what extent should specialist dual diagnosis services be commissioned for offenders? What would their role involve?

The majority of respondents believed that there was a huge need for dual diagnosis services, but stressed that this must be based on prevalence and need within the local community. Respondents differed on how these services should be commissioned; nine respondents, mainly from health sectors; felt that specialist dual diagnosis services should not be commissioned, instead suggesting that mainstream generic dual diagnosis services should work with offenders. Respondents felt that there should be training for the existing workforce to deliver dual diagnosis interventions. Similarly, that both drug services and mental health services should take on clients with dual diagnosis, with the possibility of the services being located in the same area, and with opportunities for staff secondments to increase knowledge and skills. Respondents felt that this should be a core activity or expertise of all professionals and services involved with offenders.

Three respondents felt that specialist dual diagnosis services for offenders should be commissioned, believing that they had the potential to deal with people better and to avoid offenders falling out of care due to service-level disagreements as to their suitability for inclusion.

Respondents felt that the remit of dual diagnosis services should include training and education for staff; that specialist services should sit within adult mental health services with clear pathways into drug services; and/or operate as part of IDTS teams. These services should develop new roles to target specific health needs of identified groups of offenders.

Question 17 – What should the balance of resource be between service provision for the treatment of alcohol and illicit drug use?

Many respondents believed that there was currently an imbalance between resource provision for the treatment of alcohol and illicit drug use, with much more funding and services being available for illicit drug use. Respondents highlighted a correlation between alcohol and offending and high levels of unmet need relating to alcohol (Singleton et al., 1998). One agency stated that they had demonstrated that alcohol misuse was higher than drug misuse and that there was a connection between alcohol use and offending. They believed that alcohol intervention budgets should be more than/equivalent to budgets for those to tackle illicit drugs, with respondents stating that there was a need for improved alcohol interventions (Forensic Pathways, 2007). However, respondents warned that increase funding for alcohol services should not be at the cost of funding for drug services.

Two respondents, both mental health trusts, felt that substance misuse treatment provision should be greater than that for alcohol interventions. Many respondents stated that the balance between these services should be determined locally and be based on an assessment of needs.

Question 18 – How could we effectively measure our level of success?

Respondents felt that the best way to measure success effectively was through monitoring service user engagement, in terms of numbers accessing services and disengagement/reduction in service use. This was closely followed by monitoring levels of re-offending and, specifically, alcohol-related offending. Respondents also felt that monitoring levels of need at different time points was important, with lower levels of need indicating success. Another marker of success would be numbers of people successfully diverted from custody. Respondents felt that audits and strategic assessments were important.

Question 19 – To what extent should gender specific services be delivered?

Respondents felt that the extent to which gender specific services are delivered should be based on research into the level of need. Respondents welcomed gender-focused services especially for vulnerable, black and minority ethnic (BME) and migrant women, but felt that these should be holistic services integrated into existing services rather than special strands.

Question 20 – What can be done to ensure increased diversion from the CJS for those with learning difficulties?

There were several major themes that came out of the responses to this question. Firstly, respondents thought that in order to ensure increased diversion from the CJS there needed to be more effective assessment and screening processes at all stages of the CJS, preferably at the earliest possible opportunity. Most respondents stated that assessment while in police custody would be most beneficial; others recommended during the court process, or upon reception into prison. Secondly, to enable more effective assessment and screening of offenders, respondents felt that CJS professionals needed improved training and awareness of learning disability.

Some respondents highlighted the possibility of instigating court diversion/liaison schemes specifically to cater for clients with learning difficulty, either through establishing new services or having learning difficulty input available to existing schemes. Many respondents said there needed to be more options for diversion available, including improved access to existing services and more provision of learning difficulty facilities suitable for those with offence histories within the community. Respondents suggested that more learning difficulty specialists were needed and learning difficulty nurses need to be encouraged to work within the CJS. Two respondents suggested the implementation of *Positive Practice – Positive Outcomes* (Care Services Improvement Partnership (CSIP), 2007) and the *Primary Care Contracting Framework: Managing health for people with learning difficulties* (NHS Primary Care Contracting, 2007), specifically including considerations of those in contact with the CJS.

Question 21 – What particular areas of training and practice need to be addressed in relation to people with learning difficulties?

In general, the areas of training respondents felt needed addressing were the identification, assessment, signposting and treatment of people with learning difficulty. Some respondents felt that there were specific training needs with regards to autistic spectrum disorder; the assessment of mild and moderate learning difficulty; health promotion advice around HIV, hepatitis and sexually transmitted infections (STIs) for those with learning difficulty; training that promoted thinking about the offence last and

the learning difficulty first; differences between learning difficulty and literacy problems; and learning difficulty and sexual offending. One respondent said that multi-agency accredited courses about understanding learning difficulty would be of benefit.

Other respondents felt that certain professions required particular training, including diversion teams, police, court staff, probation service workers, fire fighters and prison officers; in essence, all front-line CJS staff.

Question 22 – Are there particular equalities issues (gender, ethnicity) that are particularly relevant for people with learning difficulties?

Responses to this question were diverse; respondents highlighted many different equality issues including: age; rural populations; vulnerable females; sexuality; health inequalities; higher prevalence in men of autism and learning difficulty; the need for information to be available in different formats, i.e. easy read and in different languages; and cultural issues.

Question 23 – What support is necessary to deliver integrated services and better joint working across the CJS?

Respondents highlighted various examples of support that would be necessary to deliver integrated services and better joint working across the CJS. The most common were clear guidance or a national template, with joint targets and standards, and joint commissioning of services with joint/pooled funding. Respondents felt that shared training would allow for better understanding of other professions' roles and responsibilities. They also stated the need for improved transfer of information between professions.

Other areas highlighted included: a need for more consultation agreements and inter-service working; open and honest communication; governance structures that had the ability to compel and sanction partners for non-engagement, and which ensured that all partners had equal incentive to sign up to the introduction of the CAF; further research around what is effective within the CJS at all tiers; clear accountability and monitoring; a collaborative culture with partnership protocols; good inter-agency planning; and single points of contact for other agencies to relate to local health commissioners at a strategic level. Finally, one response noted that each PCT needed an offender health brief, and the involvement of probation services in devising care programmes.

Question 24 – What support is necessary to further develop and support integrated services and joint working for children in the youth justice system across health, education, social care and youth justice?

Respondents highlighted various areas of support needed; no one area of suggested support was highlighted by more than one respondent, and therefore responses are listed below:

- the development of joint partnerships on local and regional bases to ensure robust care pathways and commissioning frameworks were in place;
- development of a joint preventive strategy for identifying, referring and tracking young people;
- local authorities (LAs) to be aware of their statutory responsibilities to young people in custody and in the community;
- incentives to provide budgets jointly for crosscutting initiatives;

- knowledge of each other's roles and responsibilities;
- identification of vulnerable children;
- better age-specific assessments;
- the introduction of the CAF;
- better links for adolescents with dual diagnosis;
- links to be made between Youth Offending Teams (YOTs) and speech and language therapists, with each PCT to have a speech and language therapy specialist;
- an IT system that will allow information to be accessible to multi-agency teams;
- good multi-agency working and links to provide health and social care services for disabled young people, mainstreaming is key;
- better planning of the transitional period from child to adult services;
- better engagement with the Voluntary and Community Sector (VCS); and
- a role for child and adolescent mental health services (CAMHS) in preventing offending and make a high priority for health services.

Other comments

Two respondents felt that the section was difficult to read and that the priorities were not clearly stated. Two respondents felt that this section of the strategy focused too much on the individual and not enough on the community and how community services should be commissioned. Again, two respondents felt that the section did not answer the failing identified in the Her Majesty's Inspectorate of Prisons (HMIP) thematic review of 2007, *The mental health of prisoners – thematic*. Two other respondents stressed the need for improved staff training and supervision within the CJS, especially when dealing with those with learning difficulty. Of the responses from single agencies it was stated there was a need to focus on children and young people whose parents were in custody; the research and guidance section needed to include children and young people as a discrete group as their needs are different to adults; the LAA and PSA for socially excluded adults should be promoted; the link between mental health and severity of drug taking needed to be explored; and the link between offending behaviour and dropout from treatment needed to be emphasised (Durcan and Knowles, 2006). Another respondent stated the need to increase the use of arts-based interventions (Wilson and Logan, 2006; Digard et al., 2007).

Part 2: Police, police custody and Crown Prosecution Service

Vision

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

Question 25 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

The majority of non-police respondents felt that the correct priorities had been identified within this section; six out of the ten police responses also supported the priorities. Although respondents felt the correct priorities had been identified, they felt that some had been missed. The most common theme raised was the need for staff training on health, especially an emphasis on promoting cross-agency 'joined-up' training. Secondly, respondents noted a need to focus on dealing with offenders with mental illness and learning difficulty; some respondents were concerned about the number of charges/cases that are discontinued due to risk of suicide/self-harm stemming, it was felt, from a misunderstanding from the police about how to put mentally ill people through the CJS. Thirdly, concerns were expressed about the length of time it can take for a person with learning difficulty to progress through the criminal justice processes.

Respondents also raised the need for clear agreements/protocols at all levels that focused on information sharing and confidentiality. Of the responses from single agencies, these included a call to use the expertise of the British Psychological Society's Forensic Division to help develop best practice guidelines. It was also felt that it should be a priority that the Crown Prosecution Service (CPS) considered the views of mental health professionals working with an offender-patient in coming to a decision on whether to pursue a prosecution. Finally, single agency responses focused on specific groups that had not previously been mentioned, including: deaf offenders; offenders who committed alcohol-related violence, especially domestic violence; victims and their access to forensic medical services; people detained under s136 of the Mental Health Act 1983; and the availability/value of access to CAMHS in police custody.

Question 26 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for suggested practice examples.

Question 27 – Are there any significant areas which have been missed in this section?

Responses to this question fell into three main themes. The first was around assessment of offenders while in police custody. Respondents felt that there was a need to provide better health assessments for mental health and learning difficulty. Respondents felt that this would better aid signposting and diversion, with a suggestion that a requirement to meet targets or match other performance indicators would improve both rates and outcomes.

The second theme was around staff training and the provision of services. Respondents felt that staff training needed to be improved with regard to mental health awareness, learning difficulty awareness, emotional health, BME needs and child development. Respondents also felt that the current provision of health services in police custody needed to be improved, informed by a review of current models of provision. Respondents also felt that there was a lack of provision of alternatives to detention in police stations for those held under s136 of the Mental Health Act (1983); that insufficient access to child psychiatrists resulted in adult psychiatrists often being inappropriately called upon to give opinions regarding children in the CJS; and that there was a need for improved access to joint facilities for victims of rape and other sexual crime, providing a 'one stop' appropriate and caring environment.

The third theme centred on information sharing, respondents feeling that there was a need for protocol and guidance around information sharing, especially in relation to confidentiality issues. One respondent felt there should be legislative provision directing all agencies to supply basic information on offenders. Another respondent said that improving information sharing would overcome certain issues in police custody such as the continuation of prescription medication at times of limited access to health services, i.e. weekends and statutory holidays.

Respondents also felt that both BME and homeless offenders had not been effectively included in this section. Other areas mentioned by single respondents were a need to examine assumptions that people's offending was necessarily related to their mental health; the use of mandatory drug testing; issues relating to self-harm while in police custody; forensic examinations of victims; and the greater use of conditional cautioning and Court Orders.

Question 28 – How could the outcomes/outputs of these deliverables be effectively measured?

Respondents believed that there were two main ways in which deliverables could be effectively measured. The first was around measuring levels of recidivism and using crime reporting systems; the second related to using outcomes around engagement with services, including number of diversions; numbers accessing services; changes in levels of need and quality of life; and reduction in adverse incidents. One respondent suggested using the National Strategy for Police Information Systems (NSPIS) to record identified problems. Other ways mentioned in responses from single agencies included measuring how effectively police can access health and social care services; qualitative evaluation involving service users and staff; ongoing monitoring through Drug Intervention Programmes (DIPs)/DAATs and also via CDRPs/LAAs and Local Strategic Partnerships (LSPs); targets to ensure that doctors provide statements within appropriate timeframes; reduction in the number of people taken to the police station as a place of safety under mental health legislation; and better communication demonstrated through partnership boards.

Question 29 – What are the key barriers currently being faced to deliver the framework envisaged by this strategy in police services?

In response to this question four main themes emerged: training, resources, different professional cultures and information sharing.

Many respondents felt that there was a lack of police staff training around awareness and identification of mental health issues, learning difficulty and social care needs. Respondents felt there was a need for joint, multi-agency training. Only one response from a police organisation identified a deficit in training; however, five other sectors did perceive such a deficit as a barrier to delivery.

Many respondents felt that a lack of resources was the major barrier; eight of the ten police respondents to the consultation felt that resource was a major barrier. Some perceived a lack of financial commitment from government and from individual agencies. Others said that specific services, such as drug and alcohol services, lacked appropriate resources, citing that, while referral schemes may be in place, treatment services were too limited. Other respondents noted that resources were required to ensure police could support young people in custody; there was a continued lack of resources within health trusts to supply suitable places of safety under mental health legislation; and a lack of mental health resources at police stations. One respondent felt that there was a need for greater investment in a skilled nursing workforce who can lead custody healthcare services. Respondents also felt that many police custody buildings were not fit for the purpose of providing healthcare. Another resource issue was around time; police officers have limited time to process a person while in police custody and, if there were a requirement to conduct more comprehensive health assessments, this could negatively impact upon the amount of time available to investigative a crime. Additionally, respondents were concerned about the timetable for healthcare provision; custody suites are open 24 hours a day, whereas respondents reported a general pattern of 9–5 healthcare coverage. Again in relation to resources, one respondent highlighted the fact that many police services had already committed to lengthy contracts with commercial suppliers of healthcare services, with costly financial penalties for early termination.

Another major barrier was differences in professional cultures, noted by half of the police service respondents. In particular it was highlighted that the police do not readily accept the importance of their role as health related and health and social care professionals, even though they are clearly involved in the process and circumstances by which people with mental health problems are diverted from the CJS. Other differences highlighted were a lack of National Health Service (NHS)/PCT commitment to the provision of mental health legislation place of safety provision; a perceived lack of support from the CPS; different performance indicators and management frameworks; and a perceived reluctance and opposition to engagement by PCTs.

The final barrier noted was a lack of integrated information systems, single point of contact systems and a lack of information sharing.

Question 30 – How best can any competing tensions be avoided in delivering an integrated health and investigative process?

The main theme identified was around the issue of partnership working, which was felt to be key, but requiring clear remits and responsibilities; joint commissioning and funding; information-sharing protocols; shared posts and targets; and the development of effective working relationships between police authorities and PCTs. One respondent felt that one agency needed to take primacy, supported by a statement of commitment from all other partnership agencies.

A theme that came specifically from the police respondents was the need to keep the investigative and healthcare processes separate, requiring a recognition that the primary police custody function is to investigate crimes. Healthcare provision needs to be responsive, to swiftly fit in with police processes, so that delays in addressing health issues did not affect the investigative clock. Police respondents stated that current slow response times from forensic physicians ate heavily into detention time limits.

Respondents from other agencies gave specific examples of how the tensions can be avoided, for example extending the role of Multi-Agency Public Protection Arrangements (MAPPA) to include a greater number of cases; through developing local MDO panels where cases are discussed; and by providing mental health workers in police stations.

Question 31 – What are your views on NHS or NHS-led commissioning of police health services being carried out at (a) national level (b) regional level or (c) local level?

Respondents were very much in favour of NHS or NHS-led commissioning of police health services. Two respondents were not; one thought that the NHS was not equipped to take on this task, and that it would be better done through private or voluntary sector agencies, and one police respondent thought that commissioning should remain with the police. Six of the ten police responses were in favour of NHS or NHS-led commissioning, feeling that this would be a positive step forward, with major benefits including cost effectiveness, the provision of a more seamless service, improved quality and improved information sharing. Respondents stated that there were lessons to be learnt from the NHS/Her Majesty's Prison Service (HMPS) clinical improvement partnership, warning against NHS commissioners bringing in private companies to provide custody healthcare, given that a number of forces had previously commissioned in this way and reported being unhappy with the quality and standard of resultant service provision.

In relation to whether commissioning should be national, regional or local, most respondents felt that there should be a national framework stipulating minimum standards, but implemented so as to allow services to be based on local need. Only three respondents, all of which were PCTs, felt that commissioning should be regional, with local links.

Question 32 – What do you consider the police service being the 'gateway to health' should mean in terms of what happens at the police station?

Firstly, a few respondents felt that the police service should not be and could not be the 'gateway to health'; another felt that the probation service was better placed to perform such a function, requiring adequate funding to enable this.

Of the respondents who did feel that the police service should be the 'gateway to health', the majority felt that this should be the responsibility of healthcare professionals and not police custody staff. In terms of what should happen in police custody, the common theme was triage assessment, screening and signposting. Other respondents suggested that custody suites should function similarly to accident and emergency (A&E) departments, and that there should be a continuous presence of a healthcare professional, e.g. mental health nurses who could provide support in a confidential manner. Many stressed the need for proper healthcare facilities to allow full screening and assessment, this information to be subsequently passed on to courts, probation and prison, as required. Another theme related to communication, in terms of ensuring good record keeping, access to computerised records, and communication with detainees' own GPs.

Question 33 – What conflicts may exist in terms of forensic examination and healthcare and how are these currently overcome?

Most respondents indicated that there were few conflicts; one police respondent stated that they appeared to have little problem separating the issues where they both existed, and another police respondent said that the police commissioning services from the PCT had not caused problems. The main way to overcome any emerging conflict was to have clear roles, in particular in relation to decision making. Respondents felt that lines of accountability would be clearer if healthcare was commissioned from the NHS rather than by the police. Five police respondents said that forensic examination and healthcare should be clearly separated, with forensic examination taking precedence, again noting that that the investigative process should not stop for health examinations.

Respondents also felt that another way to overcome conflict was to improve the skills and training of forensic physicians in mental health, substance misuse or learning difficulties, perhaps through accreditation schemes for those healthcare professionals performing forensic duties. Another important factor was the need to improve information-sharing protocols. Single agency responses included the view that conflict would not happen if forensic physicians were part of the primary care team in police custody. One respondent felt that clinical forensic psychologists or psychiatrists could assess the functional relationship between mental health and criminal behaviour, and that this could usefully inform the forensic examination.

Question 34 – What scope do you see for wider integration of the forensic, health and social care needs of victims within this structure set out in this strategy?

Three respondents felt that the needs of the victim should not be part of the same system, but on the whole respondents welcomed this, believing that it should be an integrated service, not a separate one. Respondents suggested that this should be based on the needs of the client group. They concluded that there needed to be better assessment and treatment services at police stations, including improved services for sexual examination.

Question 35 – What level of responsibility do you envisage should be retained by the chief officer for ensuring delivery of any externally commissioned health or social care service?

The majority of respondents felt that all responsibility should remain with the chief officer, especially if they retain budgetary responsibility. However, if delivery were to be by the NHS, then responsibility for ensuring delivery could be shared. All police responses to this question felt that responsibility should remain with the chief officer. Five respondents felt that this level of responsibility should be in line with governors' healthcare responsibilities in prisons. One respondent felt that the chief officer should have no responsibility, rather contributing to a monitoring process ensuring effective delivery. One respondent said that there were two options for chief officers: that they could either be responsible for monitoring by key performance indicators (KPIs), or responsible in partnership with a PCT, reflective of the NHS partnership with HMPS. Other single respondents said that chief officers should ensure organisational compliance and strategic partnership.

Question 36 – How can we ensure that early contact with the police can be used to ensure that children and young people are accessing the health, education and social care services they need?

Two main themes came out of the responses. Firstly, the need for improved assessment and secondly, a better understanding on the part of the police of the available health and social care services for this age group. Some respondents stated that there should be an automatic referral to agencies for young people in custody, especially to social services. Respondents also noted that there should be better police liaison in schools and improved neighbourhood and community policing. The other main theme related again to improving information sharing via a system similar to MAPPA. Other responses included the need to work with priority families, to increase the input by YOTs, and the provision of information and advice services.

Question 37 – Healthcare is an established provision by police forces in police stations. What benefits and drawbacks do you consider that providing a dedicated social care provision would provide?

The majority of respondents stated that there would be some level of benefit to social care provision at police stations, with perceived benefits including access to better care, earlier diagnosis, prompt treatment, reduction in delays, help with housing, greater access to holistic care and early access to records and information sharing. Respondents said that the potential benefits to integration of services may be hampered by reluctance on the part of detainees to take advantage of services linked to the police. It was highlighted that police budgets were not adequate to cover any additional expenditure incurred and that such a model would need careful consideration to avoid social care becoming a dumping ground for problem cases. Again, increased pressure on already overworked custody staff and resource implications were raised, and concerns expressed that police stations would become a 'one stop shop' for all needs, with a public perception that too much support was being given to offenders.

Question 38 – What do you consider is the role of the police service in providing access to social care at the police station?

Respondents felt that this was an important opportunity to identify potential health and social care needs and consider early referral. Therefore there needed to be good assessment services, and effective signposting of individuals to appropriate services.

Question 39 – What are the opportunities for developing positive health and social care interventions by working alongside community policing?

The main opportunity identified was for early identification and reaching out to those who are difficult to engage with mainstream services. Early identification would help identify emerging health issues before they escalated, could lead to prompt intervention and reduce the risk of people falling through gaps in service, making contact with people who wouldn't otherwise access services. Other benefits mentioned were a reduction in the fear of crime and opportunities for professionals to learn more about each other's service. In order to do this, respondents said there was a need for joint training and dedicated resources.

Other comments

Respondents made several other overall comments about this section, many were responses from single agencies. There were only two suggestions made by more than one respondent and these were for better information-sharing protocols and ring-fenced joint funding.

Responses from single agencies were as follows:

- a need for greater involvement of the CJS with health;
- a need to sell to the public the benefits of a cohesive approach as there is the view that offender health is worthless;
- more focus on issues around drug-related deaths and prevention work with YOTs and looked-after children; and
- a need to increase and improve joint funding, especially for violent and alcohol-related crime.

Another respondent stated that the document continually suggests that people with mental health problems will not be pursued through the CJS, but will be diverted, indicating that there needed to be greater clarity surrounding this. Another said that regrettably there is nothing transparent or responsive in the eyes of the victim.

Part 3: Courts and sentencing

Vision

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

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

Respondents commented as follows.

Question 40 – Are the correct priorities identified in this section, if not, can you suggest any alternatives?

Responses from three agencies suggested that health needs assessments should be completed prior to appearance at court. It was suggested in single responses that a community forensic team should conduct a pre-court assessment of need and that there should be pre-court restorative interventions in place.

It was apparent from the responses that courts were not perceived as being fully aware of available community support services. Several respondent agencies suggested that court staff needed to increase their knowledge of the services at their disposal.

Two respondent agencies stated there was a need for specialised mental health and substance misuse workers in court, to inform decisions about Community Orders with conditions.

One response stated that during the process of sentencing young people to custodial settings, youth courts should include a realistic and meaningful assessment of a child's welfare needs. This respondent agency has requested that Section One of the Children's Act (1989) apply to youth courts, so that a 'welfare checklist' was completed for every child facing criminal proceedings. It was also suggested that courts should also be required to follow the ECM Outcomes Framework.

Question 41 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 42 – Are there any significant areas which have been missed in this section?

Two respondents suggested a need for better assessment and diversion for people with learning difficulties. A further two respondents suggested there was a priority need for training court staff about the needs of people with learning difficulties, HIV and hepatitis, and related training for health and social care staff to increase their understanding of sentencing options. Other suggestions for change from single agencies were:

- better assessment and treatment for alcohol abuse;
- better housing provision;
- support services for women guided by recommendations from the Corston Report (Home Office, 2007);

- meeting the needs of 17-year-olds who no longer wish to live at home but have difficulty gaining other, suitable accommodation;
- improvements to bail support schemes to avoid custodial remands; and
- better provision to meet the needs of people with personality disorders, women, the homeless, and BME groups.

Question 43 – How could the outcomes/outputs of these deliverables be effectively measured?

Single responses to this question suggested an overarching multi-agency framework was needed, possibly via LAAs, to measure the outcomes/outputs of deliverables. Suggestions of what could be monitored included: numbers diverted into mental health services; number of people assessed in court; referrals to services; recidivism rates; percentage assessed for need and percentage needs met; and the number of mental health reports requested.

Question 44 – To what extent would the provision of a specialised mental health and substance misuse court-based service be (a) desirable and (b) realisable?

Dichotomous responses were received; half of respondents believing specialised courts for mental health and substance misuse were extremely desirable and half that they were inappropriate. Of the respondent agencies against specialised courts, several believed that it would be better to provide mainstream court staff with training to foster an understanding and awareness of mental health and substance misuse issues. One agency felt very strongly that it was wrong to create specialist provision while another felt it better to designate certain courts as centres for mental health and/or substance misuse assessments. It was also suggested that the stigma attached to such specialist courts could lead to further social exclusion and that there were more appropriate care pathways which were realistic and cost effective.

Of respondent agencies that were in favour of the provision of specialist courts, barriers to implementation were noted, including funding, cost effectiveness and practical difficulties in their administration. One agency felt that, although they were desirable, they would be unrealistic given current delays in obtaining psychiatric reports.

Finally, one agency suggested we should learn from the USA where substance misuse/drug/family courts have already been piloted. They stated that positive results had been found so far if the sentencing official knew the case and had a relationship with the staff involved with an offender's rehabilitation, including schemes where all required services including treatment, housing, benefits and the court itself were all situated together under one roof.

Question 45 – What changes are needed to ensure the better functioning of youth courts?

Eleven responses to this question were received. Two responses suggested the need for better court diversion and two highlighted the need for community psychiatric nurses (CPNs) or other health professionals to cover youth courts to prevent lengthy adjournments for psychiatric reports. The other respondents all proposed different kinds of change, namely:

- compulsory training for magistrates on the role of YOTs, mental health and substance misuse issues;
- early referral mechanisms;
- the need for advocacy;

- a more co-ordinated approach to enable social workers from a child's home area to retain responsibility for their charges;
- stronger powers for district judges to deal with those unfit to plead;
- linking courts and treatment services local to the service user/offender; and
- improved screening to identify learning difficulties, personality disorders, mental ill-health and social care needs.

Question 46 – Would the concept of women only courts be plausible?

Twenty-one agencies responded to this question. Five agencies advocated 'for' women only courts, 15 'against' and one agency stated they didn't know. Of the five agencies who are 'for' women only courts, one felt that based upon the Corston Report (Home Office, 2007) and our increased understanding of the specific issues relating to women offenders, women only courts would be the way forward to ensure alternatives to custody were sought and/or diversion out of the CJS was considered, particularly for those with mental illnesses and/or substance misuse problems. One agency suggested that they were plausible in principle, but would require considerable investment. One stated they were plausible, but raised issues over fairness. Two agencies simply replied positively, with no further elucidation.

The 15 agencies that advocated 'against' the concept of women only courts each gave a reason why they did not believe they were plausible. There were two emergent themes. Three agencies suggested there was a higher priority need for training for magistrates/court staff over and above women only courts, and two agencies felt this could give rise to discrimination issues, insomuch as, although women's needs may be different, the approach needs to be balanced and equal for all. The other responses 'against' women only courts were as follows:

- didn't see a need;
- not appropriate;
- too complex to arrange;
- need for better care pathways instead;
- would cause longer judicial delays;
- not the volume of offenders to warrant such a development;
- courts don't have access to enough volume and variety of health-related provision to allow effective alternatives to sentences, and therefore inappropriate sentences prevail. Research was required to help quantify types of services available to give courts real choice in disposals; and
- there was a need to concern ourselves with the management of women in custody, instead of treating women differently from men in sentencing procedures.

Other comments

One agency stated that there was a need to address the high numbers of non-criminal sanctions such as Anti-Social Behaviour Orders (ASBOs) being issued to children and young people, many of whom it was suggested had mental health problems or learning or behavioural difficulties. This agency stated that recently, the Secretary of State for Children said that it was a sign of 'failure' every time an ASBO is issued to a child.

Part 4: Prisons and rehabilitation

Vision

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

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

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

The questions and responses in this part are as follows.

Question 47 – Are the correct priorities identified in this section, if not, can you suggest any alternatives?

One primary theme emerged from the responses. Suggested by four agencies was the need for improved services for the ageing prison population by virtue of the complexity of their needs while in prison and their complex health and social care needs upon release. The next set of emergent themes suggested by three agencies comprised the need for the strategy to include private prisons; better services for people with learning difficulties; a re-evaluation of provision given to people serving sentences of less than 12 months (who are not covered under the offender management model), especially those with mental health problems; better health promotion; and an improvement in the procedure for transfers from prison under mental health legislation.

Two agencies stated a need for better tackling of blood-borne viruses/HIV; better assessment and treatment for alcohol problems; better physical health provision; and better information sharing between and within agencies. Two agencies also stated there was a need to develop a women-specific pathway for those in custody, with a focus on co-ordinated support between agencies, 'through the gate' support with respect to more appropriate discharge planning and sustained support/continuity of care. One agency specifically stated that this should be achieved through establishing outreach services while in prison or community, open re-engagement to enable women to return to services without lengthy assessment, and support planning processes in which women define their own goals.

There were numerous responses from single agencies as to what they felt were high priority areas:

- development of community mental health teams (CMHTs);
- improved step-down facilities for adolescents moving from custody to community;
- services for people with personality disorders;
- services for people with dual diagnoses;
- culturally sensitive services;

- better screening tools;
- improved access to psychological therapies;
- improved continuity of care;
- teaching re-socialisation skills to people on re-entry to the community;
- lesbian, gay, bisexual and transgender (LGBT) issues are distinct needs but absent from the strategy;
- multi-agency training on mental health and learning difficulties;
- less movement of prisoners around the prison estate to prevent this impacting upon continuity of care and resettlement planning;
- improved links between healthcare and disciplinary staff on issues such as self-harm and risk of suicide;
- addressing the issue of erosion of healthcare staff's professional identities when they are dominated by prison culture; and
- improved sexual health services.

Question 48 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 49 – Are there any significant areas which have been missed in this section?

This question was answered in a similar way to question 47. The primary theme emerging was the need for more service provision and staff training on the differential needs of people with learning difficulties, with four agencies highlighting this. Themes highlighted by two agencies included a need for more provision for the complex needs of the ageing prison population; training for prison officers and other prison staff on the need to support the healthcare agenda; more holistic sexual health services in order to prevent the spread of HIV, hepatitis C, etc. (Department of Health, 1999a; Health Protection Agency, 2006); increased housing provision for prisoners on release; drug use in prison (Turning Point, 2007); and improved discharge planning with social care agencies. There was also a need to ensure that care around blood-borne viruses in prisons matches that offered in the community (Prison Reform Trust/ National AIDS Trust, 2005).

Additionally, suggestions for areas that had been missed in the proposed strategy as stated by single agencies were:

- a need to address the issue of young people being placed in institutions far away from their homes;
- smoking (Singleton et al., 1999; MacAskill and Hayton, 2007);
- anger management to be more widely available;
- reduced movement of prisoners across the prison estate;
- improved prison transfers under mental health legislation;
- considerations of physical health services;
- LGBT issues;

- improved information sharing;
- improved access to better end-of-life care for dying prisoners;
- more safer custody initiatives for at-risk prisoners;
- improved provision for foreign nationals;
- a need for improved care for the terminally ill, issues arising currently consist of security issues arises with drugs such as morphine, access to analgesia, escorts for hospital visits for chemotherapy, etc.;
- more resources for prison officers on the wings, as they are the most important resource for the well-being and rehabilitation of prisoners;
- relationships between prison and NHS staff need fostering;
- a need for staff representatives to be involved on partnership boards; and
- a need to increase provision for psychological services.

Question 50 – How could the outcomes/outputs of these deliverables be effectively measured?

Three agencies stated that healthcare models needed to be agreed and measured by regional offender managers (ROMs), and three agencies felt outcomes/outputs should be monitored by reconviction and arrest rates. Two agencies felt that more qualitative research, especially involving service users, should be conducted. Single agencies suggested the following:

- through the effective use of the care programme approach (CPA);
- through the creation of national benchmarks;
- by using holistic evaluations such as the Short Form 36 health and well-being questionnaire (Tarlov et al., 1989);
- by measuring health status pre- and post-prison;
- via a new national offender health outcomes group;
- via longitudinal measures; and
- through the use of existing performance measures.

Question 51 – How should alcohol services be funded, commissioned and delivered in prisons?

Two agencies felt that alcohol services should be integrated into drug misuse services to create generic substance misuse services, and two agencies stated they should be completely separate with their own funding streams. One agency felt that alcohol services should be prioritised over drug misuse. Six agencies that felt that alcohol services for prisons should be delivered and managed by PCTs; a further three felt they should be delivered by voluntary services, and one by in-reach teams. Suggestions by single agencies included the need for ring-fenced national funding; contracts with probation services; for alcohol services to be funded by the MoJ and NHS jointly; and/or for services to be commissioned by the NHS and provided by the most appropriate provider locally. There was also a single call for IDTS to be replicated for alcohol misuse.

Question 52 – How can we ensure that staff in young offender institutions (YOIs) and secure training centres (STCs) develop a child-centred approach? And how can we ensure that staff working with children across the secure estate are less isolated from each other and from professionals working with children in the youth justice system in the community?

The predominant answer was through a multi-agency approach with additional multi-professional training and improved information-sharing systems. Two agencies suggested the need for a national philosophy linking services together and a further two stated that a child-centred approach was not possible while young people were being placed in YOIs located so far away from their homes. One agency suggested that the DCSF common core knowledge and skills framework would be fit for this purpose.

Question 53 – How can we demonstrate that improving the physical and mental health of children in custody will enable them to achieve in education, develop skills and reduce the likelihood of re-offending?

The predominant response was through the conduct of further research with case study and longitudinal methods, and long-term mapping. One respondent referred to a need for closer links between general practitioners and social and education services as, often, GPs were aware that a child was failing and struggling but could not easily access information that would help the child. One respondent referred us to the Nacro report *Children, Health and Crime* (1998) in answering this question.

Question 54 – What needs to be done to make prison more gender specific?

Responses to this question were disparate and will therefore be listed below:

- implementation of the Corston Report (Home Office, 2007) recommendations and adaptation for prisons;
- discharge process to be rethought to consider family commitments;
- further work required on addressing the needs of foreign national women;
- a need to plan resettlement more closely in relation to housing needs;
- a need to focus on trauma;
- a need to address the needs of the trans-gendered prison population;
- improved services for families and children to visit;
- through the implementation of the work of the Women and Young Persons Group in the Prison Service on gender standards; and
- for mental health care units in female prisons to provide all services such as screening, diagnosis, monitoring and care to ensure that healthcare professionals were on-site to address gender specific needs.

Question 55 – How can health services, and forensic mental health services in particular, provide an effective input into the management of offenders who pose a high risk of harm to the public through Multi-Agency Public Protection Arrangements (MAPPA)?

Four agencies suggested that mental health and social care services should be involved in MAPPA meetings both in and out of prison and that there should be core members of MAPPA in every area. Two responses suggested this had already been put into action locally in that a respondent stated that mental health services are already members of MAPPA in the Essex area, echoed by a further respondent (area not stated). Additionally, one response stated that the contribution of forensic commissioning teams to MAPPA has been audited by Young et al., (2005).

There were numerous calls for better information sharing, joint working and communication between agencies to be improved. One agency suggested the need for more robust working protocols and one stated that it would be useful to have DH guidance, in similar vein to the non-binding best practice guidance issued by the Royal College of Psychiatrists.

Question 56 – How can PCTs ensure that they contribute adequately to a holistic 'premium' service for prolific and other priority offenders (PPOs)?

Two agencies suggested that there was a need for pooled budgets and ring-fenced funding and two agencies stated that mental health services are not sufficiently tied into the PPOs schemes except for substance misuse through the DIP. Two agencies stated there wasn't a need for a premium service.

The single responses to the question are listed below:

- there is a need for more adequate information systems;
- there is need to ensure that the host commissioner for a prison engages with the PCT to ensure local delivery;
- it is not acceptable to have a group of providers outside the current system of regulation and inspection of healthcare; they should be inspected by the new Care Quality Commission and HM Inspectors of Prison Healthcare;
- an offender health single point of contact (SPOC) or team within each PCT would improve the contribution that health can make to the service to PPOs;
- improvements to basic provision would be a start, such as access to GPs and providing an accessible prescribing service for those on drugs;
- mental healthcare units addressing individual healthcare needs should be provided. Commissioners should tender the supply of such units with a holistic specification, for example to ensure offenders have access to GP services and social care; and
- by ensuring that the PCT recognise the needs and lifestyles of PPOs may require a change in practice by PCT staff, e.g. doing home visits, evening work.

Question 57 – How can private prisons be further integrated into mainstream offender health and social care developments?

Some similar themes emerged in the responses to this question. Three agencies stated that private prisons needed to be registered and monitored by the HCC. Two agencies felt that private prisons needed to receive the same levels of funding, have access to the same information-sharing protocols and IT systems, be subject to the same inspection standards and be fully integrated with public prisons. It was suggested by two agencies that this be incorporated into their contracts. The consensus of opinion was that private prisons needed to be aligned with public prisons and subject to the same performance criteria and service evaluation.

Other comments

Other comments that were made in response to the prison questions were single calls for service improvement and are as follows:

- IDTS to be developed for young people;
- a need to ensure offenders are registered with a GP;
- more community prisons and community interventions;
- better resettlement planning and through-care;
- the pilot to facilitate transfer under mental health legislation in under 14 days to be rolled out;
- for prison to be viewed as an ideal opportunity for public health interventions such as tuberculosis screening, HIV, chlamydia and other STI screenings, hepatitis B and other blood-borne virus interventions;
- increased emphasis with the strategy about public health, health protection, health promotion and preventive work;
- that the wording of the document in relation to gender-specific services is biased, suggesting that the paragraph beginning 'The prison culture for women can be particularly harsh…' be removed as it is subjective and not evidence-based;
- that, at present, it seems the focus for prisons is on crisis management rather than individual need. The strategy needs to respond to this crisis and recognise that without overall significant change, the visions have little chance of being achieved;
- that, when prison healthcare commissioning was transferred to the NHS, funding arrangements were predicated on historical information, and there is a need to recognise that many establishments have expanded, escort costs are now included in healthcare budgets and overcrowding pressures have changed the demographics of many prisons. Therefore, a zero-based costing/benchmarking exercise might be a fairer way of reducing service inequalities across the prison estate;
- the wording of the vision may need to be reviewed, suggesting the text be depersonalised. It would also be useful to have examples of where the increased mental health funding was spent and what improvements were made; and
- the prison population aged over 60 has increased, and is still increasing; this needed to be factored into future service redevelopment.

Part 5: Probation, release and resettlement

Vision

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

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

The questions and responses in this part are as follows.

Question 58 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

The general consensus was that most of the correct priorities had been identified. However, respondents felt that better resettlement planning was needed to reduce both the risk of re-offending and of suicide/overdose on release from custody. One agency suggested that because of the numbers of people who require probation services, public protection had over-ridden the need for resettlement, rehabilitation and the linking of people with multiple needs to appropriate packages of care; thus, the balance of health and social care provision for people subject to probation services needed restoring. Respondents stated that the main priorities that needed addressing, in order of importance, were housing issues; GP registration; sexual health screening; services that met the needs of children and young people; employment issues; services for people with personality disorders and dual (or multiple) diagnoses; the needs of elderly offenders; those with chronic illnesses; and those serving sentences of less than 12 months.

There were single calls for 'custody plus' schemes and 'one stop shops', and for prisoners to be moved around the prison estate less as this was deemed to have a negative impact upon continuity of care. It was also suggested that there was a need for more focus on offenders in the community, not just those who have been released from prison.

Question 59 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 60 – Are there any significant areas which have been missed in this section?

Only a few responses to this question were received; on the whole they focused upon resettlement needs such as providing improving links between prison and probation to aid resettlement planning and continuity of care. Single responses suggested, once again, that provision for improved housing; registration with a GP; improved services for those who have served less than 12 months; and specific services for those with learning difficulties, the elderly, sex offenders and foreign nationals were needed.

Question 61 – How could the outcome/outputs of these deliverables be effectively measured?

Predominantly it was felt that outcomes/outputs should be measured qualitatively and longitudinally, through measuring self-esteem levels, confidence levels, employment levels and by monitoring increases in levels of GP registration. A single suggestion to use the OASys was received, as was a suggestion of the need to measure end-to-end continuity of care pre- and post-release (i.e. process evaluation).

Question 62 – How can a single system of case management be evolved for all offenders (including those not under a licence on release)? How can this work span criminal justice, social and health needs?

Four agencies suggested a case management model such as the Offender Management System would be best placed to do this. Three other agencies suggested that integrating OASys sentence planning and other care plans, including the CPA, would be effective. A common theme was that better partnerships and joint working with better understanding of other's roles and responsibilities (with mechanisms for raising concerns) would enable single systems approaches. It was noted that government legislation, clear lines of accountability and a CAF were very much needed.

Question 63 – What should our priorities be in relation to addressing the healthcare needs of those being supervised by the probation service?

Primarily, as suggested by eight different agencies, it was suggested that GP registration should be a priority. Secondly, as suggested by seven different agencies, the priority should be services for substance misuse including alcohol services (with one call for IDTS to be in place). Thirdly, as suggested by two agencies, mental health services and more approved premises and housing provision in general were priority areas. Single responses suggested a need for better assessments; 'one stop shops'; dual diagnosis services; less movement of prisoners around the prison estate; and for personal health, diet, fitness, sexual health, weight management, anger management and stress alleviation issues to be addressed. One agency suggested that before increased services are implemented, research, including a cost–benefit analysis, should be conducted.

Question 64 – How could resettlement services provided prior to release from prison be improved/ developed in relation to health and social care?

It was suggested by the majority of respondents that resettlement services prior to release from prison could be improved with improved early-discharge planning. It was thought that this could be facilitated with improved communication between prisons and community agencies, and that information – sharing protocols aided by better integrated IT systems would significantly help to foster collaborative working. It was suggested in one response that prison services should establish relationships that pre-date and transcend release. Several responses highlighted, once again, the need for offenders to be registered with a GP before release, and for prisoner movement around the prison estate to be restricted as it was felt that this hindered continuity of care and effective discharge planning.

From a whole-system perspective it was thought by several agencies that resettlement services could be enhanced prior to release by improving community provision such as housing/supported housing schemes and GP access. One respondent suggested that there was need for a single point of contact in the community to co-ordinate the resettlement planning.

Other comments

Further comments provided by single agencies were:

- that newly released offenders be exempt from prescription charges;
- discharge/plans for rehabilitation often collapsed because benefit/housing regulations did not support the plans;

- this section of the strategy should have included a sub-section on approved premises – many health-related issues arise when providing statutory accommodation for offenders in the community, for example managing suicide and self-harm risk and meeting the needs of older offenders;
- equal provision is required for foreign nationals as that for UK nationals; and
- additional resources are required for the probation services to work with people serving sentences of less than 12 months.

Section 2 – Making it happen

Part 1: Commissioning

Question 65 – How can we ensure the inclusion of offenders in joint strategic needs assessments that will be used to underpin commissioning?

There were two major themes that came out of the responses to this question; the first was the need to include offenders in the JSNA and the second was the need to use LAAs. Another strong theme was the need to specify the clear and prescriptive inclusion of offenders' needs as part of fully integrated governance arrangements between agencies, especially PCTs.

Responses from single agencies suggested the following:

- ROMs intervention;
- forums/focus groups;
- through vulnerable adults and children's performance indicators, work in partnership with NOMS;
- a 'top slice' of the NOMS and strategic health authority (SHA) budgets should be specifically allocated;
- take on board the experiences of providers;
- the provision of anonymous ways of allowing offenders to feed into needs assessments;
- third sectors need to be more involved in needs assessment work;
- inspection procedures;
- utilise the user-engagement model;
- offenders need to be considered part of the 'local population';
- by making young offenders a recognised vulnerable group; and
- by identifying a commissioner with an MDO lead, with probation brought into the commissioning process.

Question 66 – How can we ensure that services are commissioned and delivered with due regard to the challenges in implementing equality and providing cultural sensitivity?

Respondents felt that services should be commissioned based on needs assessments that take into account equality. These services must be monitored with better recording of information about minority groups, and services must undergo an equality impact assessment.

Responses from single agencies suggested:

- culturally appropriate mental health services and the availability of interpreters;
- socio-cultural specific services should be tendered for;
- involvement of community development workers from the *Delivering race equality in mental health care* (Department of Health, 2005) work stream;
- the *World Class Commissioning* (Department of Health, 2007b) programme should cover this area for PCTs;
- clear workforce development plans and policies;
- through consulting with TSOs; and
- through ensuring that there has been wide consultation about service provision with service users.

Question 67 – How can we best support the development of the aligned commissioning process?

The majority of respondents stated that, in order to best support the development of the aligned commissioning process, there would need to be a requirement for partnership working and clear accountability. This should be combined with shared priorities, shared funding and joint commissioning arrangements. Respondents felt the need for an overarching strategic framework but one that was not so prescriptive as to prevent local variation. Three respondents said that there was a need to use LAAs.

Other single responses to this question suggested:

- the need for offenders to be at the heart of the new commissioning process;
- that ROMs should play a key role in informing commissioning decisions by auditing levels of need in their area; and
- the need for clear information to inform the commissioning process, including statistics, best practice examples and advice on needs assessments and evaluations (National AIDS Trust, 2007a).

Question 68 – How can we achieve better commissioning and aligned commissioning through a plurality of providers?

Responses to this question were mixed; however, the most common way in which respondents felt better commissioning/aligned commissioning could be achieved was through joint commissioning. Other respondents felt this could be achieved through a national commissioning framework. Two respondents highlighted the importance of including the third sector in this process.

Single responses to this question suggested a need for:

- availability and budgetary responsibility;
- evidence-based commissioning;
- minimum standards to which all providers comply;
- use of specialist commissioning hubs and regional commissioning frameworks;
- aligned commissioning should be mapped onto the NHS *World Class Commissioning* (Department of Health, 2007b);

- joint health, social care and CJS staff training;
- shared or joint management posts; and
- GP registration as vital in order to make prisoners and patients visible to commissioners.

A single respondent felt that a plurality of providers would not improve aligned commissioning.

Question 69 – How can we support local authorities and PCTs in the implementation of the framework for commissioning mental health services for children in secure settings?

Responses were varied, each suggestion coming from a single agency as below:

- adequate funding for locally based secure services so that the transition between LAs and PCTs are seamless;
- through joint needs assessment and the development of shared priorities in the LAA;
- similar process to that used by NOMS and the HCC;
- including children in secure settings as a vulnerable group which require intervention as part of overall LSP inequalities;
- close liaison;
- the tendering process could be used for bespoke mental healthcare services, which would include pre-custody assessment, treatment and post-release support; and
- by providing clear guidance on the roles of both services, their responsibilities to this vulnerable group, and having joint targets.

Other comments

Respondents made several other overall comments about this section, all were responses from single agencies, as follows:

- clarity of responsibilities;
- choice of services for prisoners;
- funding for education in custody to change to LAs in 2009/10 partnerships;
- robust commissioning;
- the NHS should take the lead on commissioning of health services for MDOs;
- if involvement from TSOs is to be encouraged then funding agreements should be for a minimum of three years;
- the document states that the contracted-out prison estate is not currently accountable to any public sector regulator. However, HMIP inspects healthcare delivery in all prisons in England and Wales, regardless of whether they are run by HMPS or the private sector;
- should not integrate CPA and offender management because of conflicting emphasis; it might, however, be possible to explore an 'offender management module' within CPA or vice versa. The concept of aligned commissioning is also supported;

- commissioning for offenders is much broader than for prisoners, there needs to be support to look at commissioning implications for *all* PCTs and councils, not just those in areas that host prisons; and
- specialist primary care has a proven track record in many prisons.

Part 2: Partnership working

Question 70 – How can we ensure the inclusion of offenders in joint strategic needs assessments that will be used to underpin commissioning?

The one theme which emerged from several respondents was that of the need to include offenders in the JSNA.

Other single responses were as follows:

- ROMs/area managers (prisons) involvement;
- using the *National Intelligence Model* (Association of Chief Police Officers, 2005);
- integrated governance arrangements between agencies;
- commissioners should work with service providers to develop specifications;
- should be standard practice;
- quantify their impact on health services;
- statutory services must recognise offender population;
- focus groups, one-to-one exit interviews, complaints;
- intelligent commissioning;
- by ensuring they have an equal lead in partnership work;
- needs to be underpinned by a shared health, social care and CJS language;
- improved understanding between PCTs and ROMs; and
- it will be imperative for the commissioning aspects of the strategy to link in with *World Class Commissioning* (Department of Health, 2007b).

Question 71 – How can we support children's trusts to prioritise the needs of children in the youth justice system, reflecting the health needs of children and the links between poor physical and emotional health and rates of offending?

One theme that emerged from several agencies was for the need to shift the culture to ensure that children were seen as a priority, with a need for specific performance measures for holding children's trusts accountable. Additionally, the need to ensure links to LAAs and children's plans, ensuring that suitable education, healthcare and social care needs are properly identified and supported by increased funding. One respondent stated that there was a particular problem with transitional services as these had not developed appropriately.

Question 72 – How can this prioritisation then be extended to the children who are in secure settings outside the geographical area from which they live, emphasising the need for support services to be available prior to custody, during custody and on release, to promote the physical and emotional health needs of all of these children and young people in order to reduce the risk of their re-offending and to enhance their potential to achieve their five Every Child Matters outcomes?

There were two main themes that came from the responses to this question; however, these were only made by two respondents each. Firstly, regarding responsibility; respondents stated that there were frequent disputes between 'home' and 'host' LAs regarding accepting responsibility for care and resources. Structures needed to be put in place to remove this disincentive to service delivery, placing a duty on the local children's service to have due care for them. This may be achieved by giving young people in secure estates the status of being looked after by the LA, and therefore granting them the same rights as a looked-after child. The second theme was for improved and careful planning of transitions, to ensure that all the appropriate representatives involved with young people planned jointly. Previous experience demonstrated that once a young person moved to an inappropriate placement they were more likely to return into the youth justice system. Two other respondents suggested using the responsible officer role (Her Majesty's Stationery Office, 2002).

Two other suggestions were received from single agencies, namely an improved understanding of the CAMHS role with looked-after children and greater use of video interviewing.

Question 73 – What is the role of managed clinical networks in advising commissioners and harmonising the agendas of the plurality of providers?

There were only five responses to this question, as follows:

- introduction of YOS health teams which can feed into the bigger clinical network;
- help provide professional support;
- there was a role, but commissioning needs to be clear;
- the role was key; and
- an exchange of ideas, innovation and dissemination of best practice, developing evidence base.

Other comments

Respondents made several other overall comments about this section; all were responses from single agencies, as follows:

- avoid duplicate partnerships;
- essential partnership and culture changes;
- pooled budgets and joint responsibility;
- make attendance at Reducing Re-offending Partnership Boards compulsory/statutory and channel finance through these partnerships;
- YOT and PPO are examples of multi-agency working;
- standardise reducing re-offending measures across agencies as far as possible;
- clarity about accountability in partnership working;
- problems in information sharing;

- CDRPs and LCJBs were not good vehicles for strategic planning for health;
- not enough mention of prevention strategies;
- dedicated roles to provide support for partnership working are needed, such as modernisation managers; and
- there were significant challenges to achieving collaboration and partnership working: organisational and geographical structures; funding streams; priorities; and performance management frameworks.

Part 3: Provider development and support

Question 74 – How can the role of third sector organisations be enhanced to support the aspirations of this strategy?

Three main themes emerged. The first was the issue that TSOs needed to be included in consultations, tendering and strategic planning, and that statutory policies and strategies should emphasise the importance of including voluntary organisations and encourage collaborative working with TSOs. Respondents felt that Government needed to acknowledge that TSOs can make a very worthwhile contribution to service planning and provision. Secondly, that the role of TSOs could be enhanced through greater clarity. Respondents stated a need for clear roles and standards, with improved accountability, key service outcomes, minimum three-year contracts with exit strategies and open channels of communication. The third area where the role of TSOs could be enhanced was through funding, with respondents feeling that there was a need for better support and training for TSOs, with an increase in long-term funding.

Question 75 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

Only four respondents answered this question. Two said that the recognition of Transfer of Undertakings (Protection of Employment) Regulations (TUPE) issues was important; one respondent said that recruitment and retention of staff were issues; and the fourth respondent said that medium-secure units should be recognised for their capacity to release offenders and achieve a low recidivism rate in comparison with prisons.

Question 76 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 77 – Are there any significant areas which have been missed in this section?

There was only one response to this question, stating that the role of independent sector providers had not been defined within this section.

Question 78 – How could the outcomes/outputs of these deliverables be effectively measured?

Of the five responses to this question, two suggested measurement through the use of KPIs; one respondent said that any evaluation should involve real input from those using the services as well as those running them and that all evaluations should stand up to independent scrutiny. Another said that there should be a national indicator on a thriving third sector and the final respondent said that outcomes could be assessed in terms of supervising and reviewing appropriate cross-service development training.

Other comments

Respondents made several other comments generally about this section; all were responses from single agencies, as follows;

- the private sector has a vital role to play in co-ordinating services. This role should be recognised and outlined in this section;
- 'third sector organisations' as a term is not valued by many;
- it is welcomed that this consultation explicitly recognises the strengths of the third sector in working with disadvantaged and marginalised groups and it is hoped that this signals a real commitment to engaging the third sector not just in service delivery, but in developing strategy;
- the private sector has a vital role to play in co-ordinating services. This role should be recognised and outlined in this section if joint partnership working is going to be central to this strategy and holistic development of service provision achieved;
- commissioning arrangements needed to encourage the engagement of small third sector providers that are integrated into local communities;
- voluntary sector organisations can effectively engage vulnerable people to register with health services; and
- TSO prevention services and community cohesion have expertise to support effective outcome measurement.

Part 4: Information systems and management

Question 79 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

The majority of respondents to this question believed that the correct priorities had been identified. Of the respondents who suggested alternatives, the commonest stated was that there was a need for robust, overarching information-sharing protocols which are agreed by and 'signed up to' by all parties. There was a stated need for an aligned national IT system to ensure easy transfer of information. Funding must be made available for the establishment of compatible IT systems. The issue of confidentiality was also highlighted by many respondents.

Question 80 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 81 – Are there any significant areas which have been missed in this section?

There were four responses to this question and are as follows;

- support the automated electronic transfer of records between prisons and between prisons and GPs;
- the independent sector has not been mentioned, access and sharing of information is also not explored;
- the complexity of information sharing across CJS and health. Needs to be a national agreement between agencies and the General Medical Council (GMC) must be a partner to the agreement; and
- there needs to be an agreement to share information, perhaps a national IT system across prisons.

Question 82 – How could the outcomes/outputs of these deliverables be effectively measured?

There were five responses to this question and are as follows;

- systems delivered on time and in budget, user satisfaction surveys and project documentation;
- reduction in severe/tragic events;
- speed of information transfer;
- shared use of OASys by criminal justice, health and social care agencies; and
- procurement of a national prison clinical system which supplies an electronic health record for every prisoner that can be electronically transferred.

Question 83 – How can we ensure congruence between the different information systems that relate to children?

There were only four responses to this question. Two respondents called for the introduction of a nationwide computerised NHS and CJS information system. One respondent noted that it needed to be ensured that information regarding young people was collected in a manner that was transferable to all databases which would require the setting up of national data-sharing agreements; this would possibly require clarification in law, to ensure medical confidentiality did not jeopardise the chance of successful outcomes by forcing practitioners to work in silos. The final respondent sought a commitment from the secure estate towards the further development of 'wiring up youth justice'.

Other comments

Respondents made several other general comments about this section, all were responses from single agencies, as follows:

- the instigation of CPA through a country-wide IT system;
- 'joined up' IT systems were vital to the success of partnership working and ensuring continuity of care. 'Talking' between prisons and the community should start with the 'talking' of IT systems;
- there needed to be further research into gaps in services, especially for those transferred out of area;
- needed better management of information sharing;
- needed a strategy to support existing data-sharing protocols; and
- needed to link NOMS and health IT.

Part 5: Service user involvement

Question 84 – Are the correct priorities identified in this section, if not, can you suggest alternatives?

The majority of people who responded to this question said they thought the correct priorities had been identified. Two respondents raised issues around effective complaints procedures, other single responses were as follows:

- for people with HIV there must be ways of allowing involvement without disclosure of status;
- more emphasis required on setting up service user forums; and
- service user involvement will require investment.

Question 85 – Do you have any examples of good practice that can be cited in the main strategy?

See appendix 2 for practice examples.

Question 86 – Are there any significant areas which have been missed in this section?

There were eight responses to this question, as follows;

- potential conflicts of interest and understanding concerning the impact of the difference in duty of the partners (particularly the police) around consultation;
- improve service user perspective on Reducing Re-offending Partnership Boards;
- not clear what input those who are in contact with the CJS have had in drafting the strategy;
- involvement of user-led organisations of people with learning difficulties;
- use advocacy organisations and voluntary sector;
- service user involvement needs to be real;
- advocacy groups and TSOs were already successfully working with service users, and had established relationships. TSOs should be commissioned to do what they do best, that is liaising with secure units on the ground; and
- a need to inform prisoners that advocacy support is available.

Question 87 – How could the outcomes/outputs of these deliverables be effectively measured?

One respondent suggested that the outcomes/outputs of these deliverables could be effectively measured through enabling services to maintain ongoing relationships with service users and assessing these relationships. This, they suggested, would allow outputs to be measured in a more meaningful way than simply measuring uptake of services.

Question 88 – How can best practice in relation to consulting with children and young people in custody and their families best be shared across the secure estate?

There were three responses to this question as follows:

- each YOT needs to develop consultation processes and secure colleagues need to be aware of feedback relating to their service;
- if, for the reduction of crime and disorder, it can be shared under the Crime and Disorder Act provisions; and
- again, the same proposal to improve consultation with children in YOIs is made as a (draft) recommendation by the Youth Justice Board (YJB) in their evaluation of their safeguarding programme *Strategy for the Secure Estate for Children and Young People* (Youth Justice Board, 2005).

Other comments

Respondents made several other comments about this section; all were responses from single agencies, as follows:

- need greater involvement of service users in the design of services;
- the language of documents was not always accessible for the public;
- need to avoid stigmatisation;
- there was a need for people serving long-term sentences to re-learn social processes; and
- need more partnership, research, discussion with secure units and families, including an acknowledgement of their complaints.

Part 6: Workforce and training

Question 89 – What are the various sources of funding that can support training and supervision for those working with children in the youth justice system?

Responses to this question were diverse and have therefore been listed below:

- access to YJB training for healthcare professionals (i.e. Professional Certificate in Effective Practice, Youth Justice Board);
- funding sources are limited;
- within individual organisations and within contacts with academic institutions;
- specialist mental healthcare providers of the independent sector can offer bespoke mental health awareness training;
- very limited funding, but is crucial;
- area-based grants to LAs, PCT funding for CAMHS and youth justice;
- there should be more specific training and awareness raising for YOI and STC staff around issues of child protection and maltreatment. Importantly, there should be an emphasis on developing a strong partnership between children's services departments, YOTs and custody

providers to ensure that possible links between offending behaviour and experiences of maltreatment in young people are effectively picked up and necessary interventions are planned and offered, both before, during and after custody or community sentence;

- a review of the training needs of all disciplines involved in the field of sexual abuse needs to be undertaken and knowledge gaps filled;
- Train to Gain, www.traintogain.gov.uk; and
- individual service training budgets, DCFS, YJB.

Question 90 – What are the career pathways that can support staff recruitment and retention?

Again there were many diverse answers given, therefore all responses are listed separately:

- familiarisation schemes to promote understanding between agencies;
- multi-agency workshops;
- offender health and social care to become recognised as a specialism with a specifically devised training pathway;
- competency-based training and development;
- dedicated training courses for nurses working in secure settings;
- a university-led national prison nursing course/qualification (nursing in a secure setting);
- development of research clusters of prisons through the Offender Health Research Network;
- more innovative posts as currently no nurse consultants work in prison mental health;
- need offender health placements for health students;
- evidence-based offender health training programmes;
- national exercise to produce gold standard guidelines for interventions to have a level of competence;
- more graduate workers in primary mental health to work in prisons;
- increased access to psychological therapies (Department of Health, 2007c);
- flexible working, new roles and access to training and education;
- employment and skills passport for all staff; and
- medical training is regionally and nationally directed and training of those in contact with the CJS, particularly in prisons, has improved over recent years. For nurses and allied health professionals (AHPs), specialised and extended nursing and AHP roles and dedicated training courses for nurses working in secure settings, similar to those for A&E nurses, primary care nurses, etc., would be beneficial.

Question 91 – What are the current issues in ensuring consistency of training for staff working across the different settings in the secure estate?

The main theme that came out of responses to this question was the need for multi-disciplinary, joined-up training with national standards for all health and criminal justice staff. Other single responses comprised the following:

- the need to ensure clarity of roles and responsibilities;
- need recognised trainers that cross over all agencies;
- work by National AIDS Trust (NAT) highlighted funding as an issue preventing prisons offering training for staff around blood-borne virus;
- variety of training providers and different contracts across different PCTs, also issues in releasing staff for training due to shortages;
- need to agree a basic skill set;
- all CJS staff should have communication training;
- collaborating with universities;
- there is little information for PCTs (apart from those with prisons in their area) and LAs about the prison population and their health and social care needs, this needs addressing; and
- smoking cessation training.

Other comments

Respondents made several other general comments about this section; all were responses from single agencies, as follows:

- a mental healthcare unit within a secure facility or a community-based setting could provide local mental health awareness and diagnosis training;
- difficulty in recruiting and retaining appropriately trained staff;
- need to identify the training needs of all staff in the CJS, offender managers are not trained sufficiently in mental health nor are prison officers;
- this whole section needed to be given more emphasis – if the staff who are delivering this strategy are not sufficiently trained in mental health, learning difficulties, personality disorder and substance misuse, then it will fail;
- more training in personality disorders needed for medical and CJS staff;
- while it is important to train CJS staff on health issues it is also important to train healthcare staff on CJS agency working;
- training collaborations causing change are not in place, incentives are needed to encourage their creation;
- staff shortages and different nurses' roles;
- training regarding human rights concepts; and
- joint training between NOMs and health and an annual conference.

Part 7: Governance and performance management

Question 92 – How can the offender population be identified within mainstream performance management systems?

There were two main themes emerging, the first was around establishing specific offender indicators within existing performance management systems. The second was around information sharing. Respondents felt that improved communication between agencies would better enable the tracking of offenders/patients and sharing the information would enable performance to be measured and compared with mainstream provision. Single responses to this question suggested that there was a need to be clear on why such a breakdown was necessary and how it could benefit the individual, that they believed that these people were predominantly part of already identified deprived areas and groups and that referrals for GP registration by CJS agencies could be flagged on the primary care GP IT systems.

Question 93 – How can we identify and bring together the key indicators in relation to health, specific to offenders, throughout the offender pathway in order to measure the whole experience of the offender throughout the pathway?

Although there were several responses to this question, there was no overlap of responses; therefore they will be reported individually:

- broad indicators should be the same as in general healthcare, with localised indicators dependent on particular local needs;
- through the use of an integrated-care pathway document which followed the offender through the CJS;
- strategic assessment, but the focus on the victim and the situation environment;
- through the adoption of *Standards For Better Health* (Department of Health, 2004);
- develop a monitoring framework supported and signed by all;
- identify key health indicators for the probation services;
- local partnership arrangements for offender health similar to the DAAT model;
- complete a needs assessment, pathway development, service specification development, tender, contract and performance management;
- KPIs;
- key indicators on blood-borne viruses;
- mental health interventions, reductions in self-harming, numbers in substance-misuse services, GP registration;
- link in with other incentives such as the *Pathway to care for older offenders: a toolkit for good practice* (Department of Health, 2007d);
- through extending the OASys to include health indicators; and
- through consultations with professionals working in the CJS and offenders.

Question 94 – How can we measure the effectiveness and impact of *Improving Health, Supporting Justice?*

There were many differing suggestions to how the effectiveness and impact could be measured. One suggestion from four respondents was through the use of joint targets/standards; another suggestion from three respondents was the use of recidivism data. Other single responses are as follows:

- decrease in deaths following release;
- effective action plan;
- regulation and assessment of agencies;
- rates of suicide and self-harm;
- specific targets around GP registration, blood-borne virus testing, numbers receiving hepatitis C treatment, referral times for appointments and sexual health screening;
- research and evaluation; and
- both qualitatively and quantitatively over time, including some participatory self-assessment of increased well-being by the participant. Including the offender in any evaluation is essential as they are the recipient of the service.

Question 95 – How can we ensure that appropriate governance processes are in place and continue to be fit for purpose against change, both internal and external, to prisons?

There were ten responses to this question. Three responses suggested that the processes should be embedded in PCT clinical governance; other single responses were as follows:

- joint responsibility across partner agencies;
- through the use of existing frameworks;
- services in line with *Standards for Better Health* (Department of Health, 2004);
- Prison Partnership Board;
- in the HCC Annual Health Check;
- in place from the beginning; and
- joint research to evaluate pilot programmes.

Question 96 – How can we amalgamate prison-specific health services performance management processes into the mainstream NHS system, without losing focus on prisoners as part of the overall NHS population?

The majority of respondents to this question stated that prison health services should be part of the NHS in all cases and subject to the same targets and audits. It was suggested that there should be a coding system for healthcare records that allowed for prison-health specific targets or prison-health KPIs. Respondents suggested that for this to happen there needed to be phased integration, with pooled budgets. Another respondent suggested building in a prison-specific section into the HCC Annual Health Check.

Question 97 – How can we maintain the profile of prisoners, offenders and prison health services within the new regulator?

There were only four responses to this question and these were as follows:

- stressing the role of good healthcare;
- through JSNA and key indicators;
- maintain a champion for offender and prison health within the new regulator; and
- HM Inspectors of Prison Healthcare and the Healthcare Commission could be continued into the Care Quality Commission and also extend to private prisons.

Question 98 – How can we ensure that the HMPS gender-specific standards are accounted for?

There were only five responses to this question; three respondents suggested assurance through the performance measurement processes. No other respondent felt this could be achieved via host PCT commissioning arrangements, and the final respondent suggested the need for good monitoring and quality assurance mechanisms, using clinical governance processes as in the NHS.

Question 99 – How can we ensure that governance and performance management applies across a child or young person's pathway through the youth justice service – including the crucial post-release phase, where they will need ongoing, individualised care, often from mainstream services?

There were seven responses to this question, as follows:

- national standards for physical health;
- extend the work of the YOTs to ensure performance development;
- YOTs to use the ASSET assessment system (Youth Justice Board) more effectively to identify the amount and nature of intervention and proper use of the CAF;
- that health needs are identified by YOT/secure health colleagues and that they contribute to the planning process for young people discharged, and that PCTs are aware of their commitments to young people in the secure estate;
- where organisations have different performance management systems this can be helped by mapping them onto national occupational standards;
- via a holistic approach; and
- by working closely with YJB, DCSF and local authorities to develop joint targets relating to children and young people going through the criminal justice system.

Other comments

Respondents made several other comments about this section; all were responses from single agencies, as follows:

- research and development – the NHS holds a database of all research done within the organisation. This could be extended to include social care, the voluntary sector and the CJS;
- there must be drivers and funding to ensure change and clear guidelines on what prisons should be providing;
- there should have been a research and development section in the document. The Offender Health Research Network has already expanded to involve offender health through the CJS pathway;
- governance arrangements agreed and shared understanding of CPA, offender management, governance/management systems; and
- introducing reducing re-offending onto other agendas, with representation on boards.

Part 8: Equality and diversity

Question 100 – How can we ensure that the professional development of staff reflects the needs of their client group?

The majority of respondents to this question highlighted the need for regular multi-disciplinary, joint training, which included learning difficulties and which was based on an assessment and awareness of client need. Other single responses suggested the following:

- develop links with community development workers;
- develop personal development plans and recognised specialist training;
- proper training on blood-borne viruses;
- professional development programmes for equality and diversity to be integrated initiatives;
- review induction for new staff and appraisal and supervision; and
- need to map diversity and quality training to NOMS and ensure performance management of this.

Question 101 – How can we ensure that PCTs include prison healthcare as part of their wider impact assessment programme?

The main theme that came out of the responses to this question was the need to include prison healthcare within existing reporting and inspection mechanisms. One respondent suggested that this should be mandatory; some suggested making prisoners an explicit subset of a group suffering from health inequalities. Other single respondents suggested the following:

- the right representation at meetings;
- through educational programmes and partnership, linking with nurse education establishments;

- the Prison Health Partnership should allocate responsibility for producing race impact assessments to the commissioned healthcare provider; and
- via the HSCCJ meeting forums.

Question 102 – How can we effectively monitor the ethnicity of the offender population in the absence of joined-up IT systems?

Most respondents to this question highlighted that currently there was good reporting of ethnicity of offenders on reception into custody; respondents felt that if there were better protocols for information sharing, or if the process could be extended to police custody, then this would be beneficial. Other single responses were as follows:

- less monitoring and more implementing change;
- ensure standardised collection of data to assist statistical analysis;
- create agreed coding structure;
- should be recorded already by service providers as part of the contact specification;
- record it;
- by developing the use of OASys as a key tool; and
- by developing a central database in the MoJ that requires all involved in the CJS to report to the database.

Question 103 – How can we ensure that the gender equality duty is being delivered?

There were only seven responses to this question. Three respondents said this could be achieved through training and supervision that integrate gender equality, and a further three respondents said that it should be monitored through performance management of quality indicators. The other respondent highlighted good models such as the Together Women Programme (see appendix 2).

Other comments

Respondents made several other comments about this section; all were responses from single agencies, as follows:

- race equality is absorbed into the general diversity agenda and diluted/overemphasised;
- there is a difference in HMPS and NHS race equality management;
- interpreters, cultural sensitivity, culturally appropriate mental health services required;
- disabled access – in prisons and probation services;
- danger of being stereotyped by group identity and ‘quick fix’ solutions without proper needs assessments;
- equality standards/human rights measures in service-level agreement contracts;
- re-shape mainstream services so as to be more accessible to minorities;
- use Greater Manchester Against Crime data, plan, resources and joint working for minority services as an example;

- joint investment of different agencies to benefit BME communities;
- champions' group to represent excluded groups;
- need to incorporate services for foreign nationals with little command of English, as this provides a barrier to communication and information sharing;
- services for people with learning disabilities and physical disabilities;
- disability equality training needed; and
- religious backgrounds need to be considered.

Part 9: Capital and estate management

Question 104 – Service users – How will Partnerships inform the Offender Health team on service user views of the prison healthcare facilities and environment?

Of the responses to this question, three said through PALS, and three said through the use of health questionnaires or surveys. Other single responses included the following:

- consider monitoring of complaints and comments;
- arrangements for prisoner feedback on services received;
- as part of a needs assessment; and
- partnerships could be asked to provide an annual update to the Offender Health team with regard to prison healthcare estate issues.

Question 105 – What is the best system to forward concerns documented by PCT/Prison Governance groups? (include information on accessibility, appropriate environment – confidentiality, dignity)

Of the five responses to this question, two said through PALS, other single responses included the following:

- earlier engagement;
- governance structures and joint commissioning; and
- utilising existing processes, including risk registers.

Question 106 – How can we best make use of emerging evidence about the impact of design on behaviour?

There were five responses to this question and they are as follows:

- by asking the Prison Service 'how many mentally ill offenders are currently locked up?', then asking health services the same question; when the answers coincide, you will know there is progress;
- existing bodies need to be mapped and streamlined;
- share this evidence more widely to inform service planning;
- by reporting what does not work; and
- research.

Other comments

There were seven overall responses to this section. All seven stated that the current healthcare settings were very poor and not fit for purpose. Respondents said that HMPS/PCTs must recognise the importance of updating prison health facilities, with a need to appreciate that capital expenditure may often incur ongoing new revenue expenditure.

Section 3: Delivering the strategy

Question 107 – What are the most effective regional and local structures to ensure delivery of this strategy?

There were very mixed views by respondents on which were the most effective structures. Two respondents suggested regional networks similar to the Care Services Improvement Partnership (CSIP) model; two suggested regional partnership boards, but one respondent specifically stated that enhanced regional partnership boards were ineffective structures; however, one said that the lessons of the introduction of *The future organisation of prison health care* (Department of Health, 1999b) should be learnt and funding needs to accompany increased resource requirements. Other single responses included the following:

- delivery would be better achieved regionally, since not all PCTs will have a prison and some will have several;
- MAPPA strategic management board, MDO networks, LCJB;
- use the knowledge of PCTs that are commissioning for prisons;
- local multi-agency partnerships at local authority level;
- locally, the LSPs with CDRPs taking the lead; regionally, regional directors of public health;
- local 'offender health' leads in PCTs;
- monitoring via the LCJBs and CDRPs would be most effective as a way of meeting national PSA targets;
- through local health and social care and CDRPs;
- the final strategy needs greater emphasis on engaging LAs and PCTs in strategies and service provisions, e.g. with joint funding;
- need shared outcomes and targets perspective;
- LAA PSA; and
- the effective working of LAAs.

Question 108 – What role would third sector organisations play in the delivery of this strategy?

The main theme that came from the responses was that TSOs should play an important role, as they often provide specialist services, but that they are often limited by funding and lack of support. Respondents also made the following comments:

- TSOs are a key player in delivering services, but proper support and funding must be provided;
- planning input in areas of expertise, providing specialist services through tendering for services;
- providing specialist accessible materials for public bodies, specialist training on learning difficulties and advocacy services;
- they provide health and social care to those with specialist conditions such as HIV, and details of these organisations should be provided to offenders as appropriate. Where funding permits, voluntary organisations can work closely with offenders and provide advice for the staff of the CJS;
- TSOs feel that their role has been overlooked. TSOs can be a vessel when reaching out and extending services to offenders' children and families and also to BME offenders. The development of appropriate funding arrangements and funding periods would be a very welcome change;
- TSOs often lose out due to lack of resources and infrastructure to dedicate to partnership working. A proposal is being put forward to channel resources into the CLINKS/Partnerships in Reducing Reoffending network (Partnerships in Reducing Reoffending is a London-wide network for TSOs working with the CJS and overseen by CLINKS);
- TSOs are already key players in terms of housing support and homelessness; and
- potentially providing specialist services through tendering for services.

Other single responses suggested the following:

- it would be helpful if basic information about TSOs could be collected centrally by government using a standard format, thereby reducing the necessity to input these details differently according to the demands of each tender document. Tender documents also need to be well constructed; and
- deliver against a strategic third sector commissioning framework, through analysis such as the JSNA (Department of Health, 2007e).

Question 109 – What do you think are the key resource implications in delivering this strategy?

It was felt that the responses to this question were extremely important and that all responses should be listed. They are as follows:

- increased screening and diagnosis in the prison setting are intended to identify treatment demand. Prison healthcare teams will require significant resources;
- ensure parity of resources across all agencies;
- increasing the healthcare professionals delivering on the agenda, the writing and introduction of policies, standards and recording systems, training;
- CJS liaison services, prison mental health services, specific discharge procedures, e.g. a single system of case management;

- costs of meeting unmet need in respect of alcohol services;
- time and resources, IT and information sharing;
- training, additional services, structures for joint commissioning and performance management;
- funding should follow patients/prisoners; funds should be transferred between sector budgets;
- training all CJS staff in the identification and assessment of health and social care need will take time to achieve;
- funding, estates, workforce, facilities in police stations and courts;
- redistribution of prison healthcare budgets, such that the same proportion is spent on mental health services as on mainstream services (currently 11% vs 15%);
- in-reach teams are felt to be currently under-resourced;
- a concerted research budget to commission the research that this strategy demands;
- meaningful service user involvement requires funding;
- funding to commission expert groups to develop patient information advisory groups in key areas of offender healthcare;
- more resources in community-based activities;
- sufficient resources to ensure that the workforce has the right training and development to deliver high-quality services;
- partnership and money;
- concern that the strategy is uncosted. The resource implications in expending services, increasing awareness training, etc., will be extensive and require difficult decisions to be taken about redirecting of resources;
- some of the basic building blocks to the strategy being effective are not in place, for example the provision of a GP for all prisoners. The strategy is based on a limited evidence base, which seems to be making a set of assumptions about current service provision;
- the document is only aspirational; there may not be sufficient resources nor the correct levers in place to put these proposals into practice;
- cost implications. Both HMPS staff and NHS commissioners are concerned that the current baseline should not be spread even more thinly to encompass the new strategy;
- the identified need cannot be met within existing funding/resources;
- there is a need for better understanding of the economics of this;
- allocation of funding never done 'bottom up' based on needs and data;
- much of the current funding arrangements for prison healthcare stem from historical arrangements inherited from HMPS;
- transfer of bed watch money from HMPS to NHS will cause major problems;
- how we ensure value for money;
- need to truly open up the marketplace to all;

- address duplication of efforts;
- funding should follow patients/prisoners and be transferable between sector budgets, if necessary. However, training staff involved in the CJS regarding the identification and assessment of health and social care need will take time to achieve; and
- pump-priming monies to fund innovative pilot projects linked to clear, evaluated outcomes is also an important implication to address.

Other comments

Respondents made several other comments about this section; all were responses from single agencies, as follows:

- need clear, national information exchange agreements (including courts and the GMC);
- a national handbook summarising all known information on prevalence, effective interventions, etc., to ensure standardised and high-quality assessment;
- dedicated funding;
- so little is known about health and offending that it is disappointing that there was no opportunity to comment on research;
- lack of questions on research and development;
- lack of an evidence base for CJS policy;
- much more is needed on social care throughout the strategy;
- there is too much reference to third sector and voluntary organisations;
- due to length and complexity of the strategy, we are not able to answer questions individually;
- priorities are not set out clearly;
- the strategy uses 'health' in its title, but excludes most health and focuses on mental health, learning difficulties and substance abuse;
- no mention of complaints-handling systems;
- the strategy is light on any commitment to allocate resources;
- no mention of access to health and social care for victims;
- need to ensure that LAs are central to the structures. They are often left out by DH, but are essential to service developments;
- for this vision to be achieved, there needs to be a culture shift in thinking, moving away from the perspective of 'prison with healthcare attached' or a 'healthcare provider with a prison attached';
- need to address political will at a local and national level in terms of addressing the needs of offenders;
- organisational culture difficulties getting in the way of getting mental health services into prisons;

- breaking down professional and cultural barriers across health and social care; and
- reference needed to the *UN Convention on the Rights of the Child* (United Nations, 1989).

Respondents felt that the format of the consultation questionnaire made it difficult to read, comprehend and complete. It was stated that the questionnaires were repetitive; the first and third questions were essentially the same in the initial sections. It was also stated that the questionnaire (at 109 questions) was longer than it needed to be. Consequently, many agencies answered the questions in the initial sections and neglected the latter sections – this was reflected in the evaluation.

Therefore, it may be necessary in future consultations of this nature to produce a more concise questionnaire, avoiding repetition in order to increase the likelihood of high response rates and subsequently represent the views of a wider population.

Next steps

Once this document has been published, individual respondents will be sent an electronic copy of the final document direct and it will be made available to all.

As indicated previously, the purpose of the document is to inform the development, publication and subsequent monitoring of the national Offender Health and Social Care Strategy and to provide evidence for Lord Bradley's review. Therefore, the document will be submitted formally to the review in summer 2008.

During autumn 2008, the key suggestions will be extracted from the analysis document and reviewed alongside other key information sources and evidence. The Strategy Executive Steering Group will consider these suggestions, and those that are accepted will undergo further financial and impact analysis prior to inclusion in the final strategy.

During this time, any good practice examples identified to support these suggestions will be evaluated prior to inclusion in the final strategy.

Lord Bradley will report to Parliament in late 2008, with the Government's response and publication of the strategy in spring 2009.

Appendix 1: List of respondents including collaborators

Action for Prisoners' Families
ADASS
Age Concern England
Alcohol Concern
Ann Craft Trust
Anne Peaker Centre
Association of Chief Police Officers
Audit Commission
Avon & Somerset Constabulary Forensic Medical Examiners

Barnsley Mentally Disordered Offender group
Bedfordshire & Hertfordshire Local Medical Committee Ltd
Bedfordshire Probation Service
Blunkett, David, MP
Brake
Brighton & Hove City Primary Care Trust
Buckinghamshire Crime and Disorder Reduction Partnership
Buckinghamshire Primary Care Trust

Cambridgeshire & Peterborough Mental Health Trust
Cambridgeshire Primary Care Trust
Cardigan House
Care Services Improvement Partnership, Eastern Development Centre
Care Services Improvement Partnership, South East Development Centre
Care Services Improvement Partnership, South West Development Centre
Care Services Improvement Partnership, West Midlands Development Centre
Community Lincs
Cornwall and Isles of Scilly Primary Care Trust
Council for Disabled Children
County Durham Primary Care Trust
Coventry City Council

Department for Education, Schools and Families
Department of Health Personality Disorder Team
Devon & Cornwall Probation Service
Diocese of Lincoln
Dorset Police
Dorset Primary Care Trust
Durham Magistrates

Ealing Primary Care Trust
East and North Hertfordshire Primary Care Trust
East Midlands Strategic Health Authority
Elmore Team Oxford
Epilepsy Action
Essex Police

Faithfull, Lucy
Family Planning Association
Fawcett Society
Foundation for People with Learning Disabilities
Foyer Federation

Good Vibrations
Government Office for the South West, Regional Public Health Group
Great Yarmouth and Waveney Primary Care Trust
Gwent Police

Hammersmith and Fulham Primary Care Trust
Hampshire Constabulary
Healthcare Commission
Healthcare Support Group IMB
Hepatitis C Trust
Hertfordshire County Council
Hertfordshire Mentally Disordered Offenders Steering Group
Hertfordshire Probation Service
Heywood, Middleton and Rochdale NHS Primary Care Trust
HM Inspectorate of Prisons
HM Prison Service
HMP Altcourse
HMP Bronzefield
HMP Bullwood Hall
HMP Coltishall
HMP Downview
HMP Edmunds Hill
HMP Leeds
HMP Liverpool
HMP Pentonville
HMP Peterborough
HMP Wandsworth
HMP Warren Hill
HMP Wealstun
HMP Winchester
HMP Wormwood Scrubs
HMP & YOI Chelmsford
HMP & YOI Forest Bank
Homeless Link
Howard League for Penal Reform
Humberside Police

Kalyx
Kent Probation Service
Knowsley Primary Care Trust

Lancashire Care NHS Foundation Trust
Learning Skills Council
Leeds Primary Care Trust
Leicester City Council, Crime and Disorder Reduction Partnerships
Leicester City Primary Care Trust Health and Wellbeing Partnership
Leicester City Youth Offending Service
Leicestershire and Rutland Probation Board
Leicestershire County and Rutland Primary Care Trust
Lincolnshire NHS Teaching Primary Care Trust
Lincolnshire Partnership NHS Foundation Trust
Lincolnshire Probation Service
Linking Voices
Liverpool Primary Care Trust
London Borough of Hammersmith and Fulham
London Probation Service
London Regional Response

Manchester City Magistrates
Mencap
Mental Health and Criminal Justice Third Sector Forum
Mersey Care NHS Trust
Metropolitan Police Service
Mind
Ministry of Justice

Nacro
National AIDS Trust
National Body of Black Prisoner Support Groups
National Probation Service Performance and Improvement Unit
NCH, the children's charity
NHS Confederation
Norfolk Youth Offending Team
Northamptonshire Probation Service
North West Regional Offender Management
Nottinghamshire Healthcare NHS Trust
NOMS Estate Planning and Development Unit
NSPCC

Orchard Community Care

P3
Parlimentary and Health Service Ombudsman
Penrose Housing Association
POhWER
Partners of Prisoners and Families Support Group (POPS)

Prison Health Commissioners Network
Prison Healthcare Managers Network
Prison Officers Association
Prison Reform Trust
Prisons and Probation Ombudsman

Respond
Restore 50 plus Age Concern
Rethink
Revolving Doors Agency
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Speech and Language Therapists

Sainsbury Centre for Mental Health
Samaritans South West
Secure Environments Group
Serco
Service user groups including serving and ex-offenders
Sheffield Drugs and Alcohol Team
Sheffield Primary Care Trust
Skills for Justice
South Essex Partnership NHS Foundation Trust
South Wales Police
South West Consultants in Public Health
South West Probation Service
South West Yorkshire Mental Health NHS Trust
South Yorkshire Eating Disorders Association
Staffordshire Council Social Care and Health
Stepping Stones Trust
Suffolk Mental Health Partnership Trust
Suffolk Primary Care Trust
Suffolk Supporting People
Suffolk Youth Offending Service
Supporting Others through Volunteer Action

Terrence Higgins Trust
The British Psychological Society
The Care Programme Approach Association
The Magistrates' Association
The Priory Group
The Young Foundation
Together
Turning Point

University of Lincoln

Voice UK

Warwickshire Police
Warwickshire Probation Service
Well Being National Children's Bureau
West Essex Primary Care Trust
West Hertfordshire Primary Care Trust
West Midlands Probation Service
West Yorkshire Probation Service

Young Offender Education Team
Youngminds
Youth Justice Board East/East Regional Team

Zahid Mubarek Trust

11 million

Appendix 2: Practice examples submitted by respondents

NB – None of the examples below have been formally reviewed or validated by the Department of Health or any other independent body for the purposes of the consultation.

Introduction – How we would like it to be

Question 2 – Do you have any examples of good practice that can be cited in the main strategy or the Children and Young People's strategy?

HMP Warren Hill promotes chlamydia screening and safe sex, a Patient Advice Liaison Service and a pilot Independent Complaints Advocacy Service, which provides support when an NHS complaint becomes formal.

Leicester, Leicestershire and Rutland have reducing reoffending boards, which work across a broad spectrum to identify and support opportunities for better partnership working and aligned commissioning.

Psychiatric screening takes place at police custody and court stage in Hertfordshire. The Community Information Unit in **Hertfordshire County Council** is in the process of becoming an information hub for all information, including health. This data is then mapped, which can inform need/ planning and can assist in early intervention and will soon be rolled out to include all PCT data.

The **SWAN** (Sex Workers around Northamptonshire) pilot scheme reaches out to women in the sex industry. It aims to improve the quality of life for local communities and reduce drug-related crime, by tackling health inequalities, homelessness and drug use. The project has also been enhanced to include a supported housing scheme, **NEST** (Now Exiting the Sex Trade), which also increases opportunities for training and employment.

Sheffield PCT is providing screening and brief interventions alcohol training to all primary care teams across the city, with a particular emphasis on those areas of highest deprivation, which the majority of ex-offenders released from Doncaster prison migrate to upon release. This training will also accommodate attendees from other disciplines, e.g. housing, neighbourhood wardens, police community support officers, community forums, Connexions workers, in order to maximise continuity and joined-up working in specific geographic locales.

Sheffield PCT Enhanced Public Health Programme (Local Area Agreements) is training mental health professionals (statutory and voluntary, community and faith sector) to run 20-week anger management psycho-educational groups for men which will receive referrals from all agencies (police, children's centre, GP practices and self-referral).

Ten councils and their partners (communities, criminal justice agencies and public sector providers) in **Leicestershire, Leicester City and Rutland** have been testing how a **Civic Society Alliance** will work in practice, with support from the National Offender Management Service. Together they have developed a toolkit, demonstrating how you could develop a Civic Society Alliance to reduce re-offending in your area.

Ealing YOT had health representatives who were fully involved in the development of the Youth Justice Plan and the setting of a strategic direction. They provided leadership to the YOS, particularly on mental health issues.

The work of the **Newcastle-Upon-Tyne YOT** has been fully integrated into partner strategies. The commissioning arrangements for substance misuse and CAMHS ensure that the YOT has good access to these services.

Devon and Cornwall Probation Service obtained Department for Work and Pensions funding for its 'Warbarth' (meaning 'together' in Cornish) employability enhancement programme, which targets everyone for whom offending is a barrier to gaining employment and has been very successful.

By redirecting a small proportion of the funding that would otherwise be spent on secure residential placements, **Plymouth learning disabilities** commissioners developed a community Sex Offenders Treatment Programme (SOTP) with the **NSPCC** for learning disabled service users who present a risk to children. Shared commissioning and delivery of the community SOTP in Plymouth and South Devon between the probation area, PCT and NSPCC deliver an integrated programme, which mitigates the risk to children, while supporting the safeguarding agenda, linking with the children's and young people's agendas, as well as delivering the required crime reduction inputs.

The **Healthy Living Project (HLP) in Lincolnshire** demonstrates excellent partnership working between the Probation Service, PCT and the Partnership Foundation Trust, all of which contribute to the management board. It takes a holistic view of health and works to promote health and improve access to mainstream healthcare for offenders under probation supervision, through screening, assessment, advice, signposting and referral. The HLP uses nurses to link offenders with dentists and GPs and to provide health education (particularly on alcohol). Having nurses in Probation acts not only as a valuable resource for offenders but also for offender managers. Case managers have reported that the HLP has provided them with new means to support clients, both by providing them with increased confidence to know how to recognise and respond to certain health issues and by providing new pathways to direct clients. The centre has a first reception healthcare screen within approved premises and probation offices, which identifies risk of self-harm and any healthcare problems requiring immediate medical attention, and facilitates signposting to appropriate services.

The **Together (Working for Wellbeing) Forensic Mental Health Practitioner Service**, jointly funded by London Probation and PCTs, operates in seven London boroughs and three London Magistrates' courts. It is run by Together (Working for Wellbeing), a national charity working for well-being, which supports people with mental health needs by: running a range of services across the country; campaigning and research; and educating local communities about their own mental health needs. Following a serious incident in 1995 by a mentally disordered offender, London Probation began to look at how greater support could be made available to probation officers to understand and negotiate the complexities of inter-agency, multi-disciplinary working with mentally disordered offenders. The service has grown from a single practitioner to a service operating across seven London boroughs, offering a diverse range of service provision to mentally disordered offenders.

In **Warwickshire**, funding was obtained through local authority channels to have an **Alcohol Treatment Requirement** (a tailored alcohol treatment programme ordered by the courts) delivered by a third sector organisation. Also developed were an Alcohol Arrest Referral Scheme and a Mentally Disordered Offender Scheme and diversion/liaison schemes.

Healthier Inside is a national project that aims to improve the health and well-being of young people in secure settings. The programme supports and shares effective practice, to make secure settings as safe and healthy as possible. Healthier Inside and its toolkit are bringing together all national policies and guidance to form one clear set of entitlements, which are placed within the five Every Child Matters national outcomes (see below).

The **Life Routes** programme, managed by the National Children's Bureau, is a national programme which aims to help young people develop essential life skills through work within schools and communities. Life Routes aims to help young people achieve the five national outcomes outlined in the Government's Every Child Matters strategy which are: to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

Turning Point staff in the **Drug Intervention Programme** team in **Somerset** have an effective partnership with their probation area and with the Prison Service, to address substance misuse by offenders. They work in multi-disciplinary teams based in probation offices – a team approach. The team includes members of probation staff and an NHS nurse. They not only share an office, but also facilitate group work jointly, have weekly team meetings, discuss cases freely and make joint decisions on individual plans. All team members work out of each other's bases. For example, Turning Point runs groups and clinic sessions at the NHS drugs clinic and sees referrals for assessment and one-to-one appointments at the local Turning Point office. The Turning Point team members are known by the other individual team members and are warmly welcomed by them. Although the different workers come from very different professional backgrounds, they work together effectively.

The **Stepping Stones Trust** is a four-phase resettlement programme for offenders, which incorporates the seven reducing re-offending pathways. It includes Beyond the Wall at HMP Wormwood Scrubs, HMP Belmarsh (from spring 2008) and HMP Brixton (closed in October 2007). Pathways are explored in personal development plans and referrals are made as necessary. They provide assistance with accommodation, referral to drug and alcohol services and GPs on release, family issues, etc. Hostel provision with key worker support, together with structured recovery programmes and mentor support, is also provided. Stepping Stones also runs a hostel in a religious environment for convicted sex offenders and has effective partnerships with the commissioners: Supporting People, the Probation Service who run Sex Offender Treatment Programmes, MAPPA, Christian churches, Battersea Fields Surgery (a Christian GP practice), local police, Jobcentre Plus and Social Security/Housing Benefit Agency. The success of the programme was validated by Wandsworth Police in their 2005 audit.

Respond delivers a Young People's Project that provides psychotherapy for young people with learning difficulties aged 5–18 who have experienced trauma or abuse. They provide individual counselling and psychotherapy, which includes the use of art, play, sand, drama and movement therapy and also education and training services to other services and community groups. Respond also risk assesses and provides early intervention to help young people to avoid contact with the criminal justice system. If a young person does commit a crime, then Respond will liaise with the courts and provide valuable insight about them.

A **Valuing People Support Team** project is running a pilot in the South-East, providing learning disability awareness training for prison staff.

The **UK Forensic and Learning Disability Network** is aimed at practitioners and those with an interest in people with a learning disability in secure settings, who are in or at risk of contact with the CJS. They disseminate good practice and other information. The network can be accessed via: www.jan-net.co.uk

The **UK Child and Adolescent Mental Health Network** disseminates good practice and is open to anyone with an interest in the development of good mental health provision for children and young people with learning disabilities. It can be accessed via: www.jan-net.co.uk

SOVA's Holistic Approach to the care of offenders, evidence of this is the **Dependency to Work Programme**. A pan-London Single Regeneration Budget funded programme, which offered a holistic approach to the support, dependency and employment needs of offenders. Specialist agencies were subcontracted and 'one stop shops' set up to deliver the work.

Joining up Justice, run by the third sector organisation **Skills for Justice**, brings together all the key justice agencies, including police, prisons, youth justice and the third sector, in order to facilitate cross-sector problem solving and decision making, while promoting a culture of multi-agency working. It is funded by the South East England Development Agency. It is expected that this model will be adopted in other regions and could form the basis of a cross-sector approach with health, social care and justice.

The **Good Vibrations Gamelan in Prisons Project** has worked in 16 prisons and secure hospitals across the UK, with over 1,000 individual prisoners and patients having benefited from taking part in gamelan workshops. Good Vibrations has been found to be particularly good at engaging those who can be 'hard to reach', and aims to help prison inmates develop team-working, communication and other important life skills through participating in workshops. The project's work in Peterborough with female prisoners who self-harm reduced such incidents, leading to their removal from ACCT (Assessment, Care in Custody and Teamwork) and re-engagement with other prison activities.

The health sector in **Plymouth** is working with the NSPCC on a new assessment and treatment service for adult male sex offenders who are learning disabled. This is an innovative practice development that provides a service for this group in the absence of an accredited community programme.

The **Safe Treatment Scheme** for violent and aggressive patients, set up in conjunction with Care UK and running in central **Luton**, is evidence of a good model for joint working with the Probation Service, particularly for high-risk offenders in order to ensure that they remain linked into primary care services and to provide a safe environment.

Hampshire Probation Area Health Trainers are ex-offenders who are employed by Portsmouth PCT, seconded to Hampshire Probation Area and trained at a local college. They work with offenders in the community in Portsmouth to give advice and guidance on how to access the various health agencies in the area, and also help offenders to make positive changes to their lifestyles. This has now spread to Southampton, the Isle of Wight and other parts of the country. To date, there are 16 health trainers employed in total, though only the Portsmouth ones are employed directly by the PCT.

The secondment of an Offender Manager to the community personality team based at **St Nicholas Hospital in Newcastle** has provided the resource to deliver staff training to probation, and has improved management of personality disordered offenders, including input to multi-agency public protection meetings.

The partnership between **North East Council on Addictions** (third sector) and **County Durham Probation Area** provides alcohol treatment requirements to offenders and Tier 3 structured day care to non-offenders.

ViSOR (Violent and Sex Offenders Register), a sex offender and violent offender database, is due in every prison this year. This represents a significant contribution to public protection, in particular for children and vulnerable adults in the community.

The **Together Women Programme** aims to make a difference to the lives of women offenders and women at risk of offending, by working with key workers and community-based women's centres. Within the Together Women Programme centres in **Leeds, Doncaster and Bradford**, women can access advice on health, education and training, housing, substance misuse, finance and family issues. All the centres provide crèche facilities so that service users can focus on the issues they need to address, while their children have fun in a safe environment.

The **Greater London Alcohol and Drug Alliance** is a good example of effective strategic partnership working, based on existing regional partnerships. The alliance aims to improve collective responses to alcohol and drug problems, and to provide a mechanism to tackle London-wide priorities.

Leicester YOS has a generic health nurse with a school nursing background who has been seconded to the team. Her role is to assess and support young people regarding their general and sexual health.

Section 1 – The opportunity for change

Part 1: Communities and responsibilities

Question 13 – Do you have any examples of good practice that can be cited in the main strategy or the Children and Young People's strategy?

A speech and language therapist and Northgate and Prudhoe NHS Trust are working with the local police to provide training on communication needs.

Leicester City, Leicestershire and Rutland Offender Health Viral Hepatitis Forum is developing a care pathway.

Bolton One Stop: the Parallel Centre aims to work with young people in securing their right to a positive and healthy lifestyle. The centre provides a range of services, including general health, sexual health, contraception and midwifery, lesbian, gay and bisexual support groups, emotional health, signposting, substance misuse services, and the health-related holiday project. It has extensive partnership working arrangements with various agencies, including voluntary, criminal justice and health agencies. The young people are involved in decision making regarding the delivery of healthcare services.

Leicester Young People's Team is a dedicated mental health team specifically for looked-after children, young offenders and homeless young people.

Head2Head, based in **Nottinghamshire**, is a dedicated team for the YOS providing a 'dual diagnosis' service. The service is a nurse-led team, with specialist substance misuse workers providing support for young people with significant emotional or mental health problems and who misuse substances or who have been affected by the misuse of substances by others. It also provides a detoxification service and ongoing support for young people who are dependent on a substance.

Through the national development programme, the **Revolving Doors Agency** is identifying the needs of offenders with common mental health problems and multiple needs. The Agency is collaborating across operational and strategic levels of local health, social care and the CJS. This will provide a potential model for the delivery of local health needs assessments for offenders and a developmental mechanism for the translation of the findings into commissioning decisions and local services.

Based at **Huntercombe Young Offenders Institute**, Huntercombe Educational Psychology engagement is an example of good practice, where the senior educational psychologist works with other professionals, including from health and education, in establishing screening systems to identify young people who need additional support during activities and working with the disability officer. Together with the case worker and YOS, the educational psychologists at Huntercombe also establish needs and appropriate support for the young offender when they are returning to the community.

Research trials on **multisystemic therapy** (MST) (e.g. Henggeler et al., 1999) indicate that this is a useful community-based approach for working with young offenders and their families. MST involves helping the parent/carer with specific and practical advice and guidance about how to set rules and boundaries aimed at improving the young person's behaviour in order to avoid them getting into trouble and helping parents/carers maintain these boundaries. MST involves working with both the parent/carer and the young person, providing guidance, advice and support.

The **Forensic CAMHS (Ardenleigh)** in Birmingham provide a team of mental health professionals who specialise in working with young offenders with complex developmental and mental health needs.

The **Common Assessment Framework (CAF)** is a key part of delivering front-line services that are integrated and focused around the needs of children and young people. The CAF is a standardised approach to conducting an holistic assessment of a child's needs and deciding how those needs should be met. It can be used by practitioners across children's services in England. The CAF shows evidence of good practice for having a multi-agency approach to early intervention, and it has been suggested that a similar system be implemented for young offenders.

National Addiction Centre at the Maudsley Hospital in London: the hospital has opened the first pilot scheme allowing registered addicts to inject prescribed 'clean' heroin at the clinic, using sterilised equipment. The scheme/trial was recently reported favourably in the media. It has drastically reduced crime within the test group and the local area and, following the completion of the trial (if results support it), should be rolled out progressively across the country.

Part 2: Police, police custody and Crown Prosecution Service

Question 26 – Do you have any examples of good practice that can be cited in the main strategy?

The **Criminal Justice Liaison Team** (CJLT) is a criminal justice based mental health liaison service in **Mersey Care NHS Trust** addressing the needs of mentally disordered offenders at points of the CJS. The team is regularly involved with partner agencies, e.g. police and probation, and in the assessment and management of risk. The CJLT works not only within the Adult Mental Health Directorate, but also across the whole of Mersey Care NHS Trust, acting as a central point of contact for any Mersey Care service user anywhere in the CJS.

Lincolnshire Partnership NHS Trust has developed a Community Forensic Team that will provide assessments, advice and support to individuals residing in the community who have a mental illness and who are at risk of offending behaviour. The service provides a court diversion scheme through close liaison with local police and courts, in which individuals with a psychiatric disorder who are better managed by psychiatric services are moved out of, or supported within, the CJS.

The **Crown Prosecution Service** carried out a public consultation on its 'Policy for prosecuting cases involving the intentional or reckless sexual transmission of infection' (Crown Prosecution Service, 2006). This allows concerns around HIV to be raised and addressed in their final guidelines.

Gwent Police has secured funding from the Welsh Assembly Government for mental health intervention in custody suites.

Dorset Healthcare NHS Trust has provided mental health assessment provision to Poole and Bournemouth police stations. This ensures that mental health needs are identified and addressed at an earlier stage of the criminal justice process.

Islington Neighbourhood Link Worker Scheme, operated by St Mungo's and supported by Revolving Doors, has been established in partnership with the Metropolitan Police's Safer Neighbourhood Teams (SNTs). Mental health link workers work with three of Islington Police's SNTs to identify people at arrest whose unmet mental health needs put them at greater risk of low-level offending and anti-social behaviour. Link workers provide a combination of practical and emotional support, enabling people to access health and social care services, such as registration with a GP, drug and alcohol rehabilitation and housing support. Evidence about the unmet needs of those referred to the scheme by the SNTs will be fed back to local commissioners, thereby informing their practice.

Section 136 Project in Leeds: the Becklin Centre in Leeds is a place of safety for those detained under Section 136 of the Mental Health Act. The multi-agency approach combines the services of Leeds Mental Health Teaching NHS Trust in conjunction with West Yorkshire Police, Leeds Primary Care Trust, social services and the Ambulance Service to enable the assessment of a person whom the police believe to be suffering from a mental disorder and in need of immediate care. The place of safety enables the person to be examined by a doctor and interviewed by an approved social worker.

Knowsley YOS health team supports the YOS and therefore at times is able to deliver concurrent health services or to signpost individuals to appropriate health services while they are at police custody stations.

Kent Constabulary Custody Nurse Scheme: the nurse-led scheme improves the standard of care of those detained in police custody.

Dorset Police has commissioned **mental health services**. The CPN provides information and advice regarding mental health, and has access to NHS information databases, so is able to offer advice to custody staff in relation to care plans for detainees and, if necessary, to co-ordinate the call-out of the crisis team. This enhanced information informs the custody officers' risk assessments at an early stage and therefore reduces risk to all.

Dorset Police has consolidated separate **drug/alcohol intervention protocols** into one pan-Dorset document. Referral to Drug Intervention Programme (DIP) teams by custody staff is now seen as a priority and all eligible detainees should be referred. DIP workers visit each suite daily and, when the process becomes electronic, all detainees' information will be captured.

Dorset Police is liaising with its local PCT with a view to commissioning **medical services** within police custody settings for offenders and victims of crime. A programme and project board have been set up and they are nearing agreement. This will inextricably link the NHS to custody and will facilitate care pathways.

Sussex Police stations provide packs containing **safer injecting equipment** at custody suites. Injecting equipment is taken from people who are detained in the cells, and on release after questioning, they are given clean injecting equipment and signposted to the needle exchange service. Release from custody is a time when injecting drug users are particularly vulnerable to increased risk-taking behaviour.

Humberside Police custody nursing scheme has significantly lifted the level of support to police and detainees. Not all detainees are seen, but those who are referred to the nursing team do receive on-site help and medical support, and are signposted to other agencies.

Camden Borough in the Metropolitan Police has a dedicated mental health information officer who provides full-time information sharing and support between the police and other agencies. This has built up a trust and expertise among practitioners and has encouraged health agencies to share information regarding the details of individuals from a medium-secure unit who have dangerous offending histories. This means that the police are able to advise on placement in the community and to put in place monitoring and public protection arrangements in cases where the offender falls outside the MAPPA criteria.

Cleveland Police operates a **Young Persons Custody Project**, referring young people to relevant services. There is also 24/7 nursing provision within custody suites.

Humberside Police: a local PCT provides **24/7 nursing services** within the main custody suites, which has proved extremely successful. Further negotiations around the PCTs providing services and supportive funding of the local sexual assault referral centre are also positive.

Lancashire has criminal justice mental health liaison workers, who are provided by Lancashire Care Mental Health Trust. They work within custody sites to assist with detainees who have, or who may have, mental health problems. They consider interventions, assist in assessments, liaise with courts and probation and generally assist with the detainee from time of arrival at custody.

Norfolk Constabulary has approved social workers, CPNs and alcohol referral workers integrated into the custody suites.

Devon and Cornwall Police has nurses in custody suites working with partner agencies (this makes for a better working relationship between agencies and the police, as clinicians can liaise with each other) and also provides assistance in carrying out treatment for minor injuries, etc., relieving A&E departments.

Warrington Police Pilot: as part of the National Development Programme, the Revolving Doors Agency is working in collaboration with Warrington Police and Community Mental Health Team in order to develop a pilot model of support for people with unmet common mental health problems and multiple needs. There are four key elements to the proposed pilot:

- community action teams (among other police) will refer people with unmet mental health needs to local statutory mental health services;
- two mental health professionals will work in the community to assess individuals referred by the community action teams and link them directly into a range of support services;
- in the most complex cases, comprehensive solutions will then be negotiated at multi-agency case review meetings; and
- a local steering group will strategically and systematically evaluate the pilot in order to inform wider system reform.

The Haven, a sexual assault referral centre based in London, provides a confidential service for survivors of sexual assault and rape. It offers medical, forensic, practical and emotional support and counselling services. It has a co-ordinated approach to crime investigation, victim support and healthcare provision.

Mersey Care PCT provides mental health diversion schemes at court and police levels. Private nurses have been contracted to work within some custody suites in Merseyside.

Part 3: Courts and sentencing

Question 41 – Do you have any examples of good practice that can be cited in the main strategy?

At **North Liverpool Community Justice Centre**, a community court acts as both a Magistrates' and a Crown court. It deals predominantly with offenders with substance misuse history and mental health problems and those with a dual diagnosis. An Alcohol Treatment Requirement programme is being piloted under the provisions of the Criminal Justice Act 2003. In addition to medical support provided by specialist substance misuse workers and work on offending behaviour, assistance is provided with housing, employment and social interaction.

The **Home Office's intermediary scheme** provides communication support for vulnerable witnesses, helping them to communicate more complete, accurate and coherent evidence in court. Vulnerable witnesses include children and young people under the age of 17 and people with physical, mental or learning disability disorders. Over 80% of intermediaries are speech and language therapists, which emphasises the key role played by speech and language therapists in meeting the communication needs of children and young people.

Knowsley Youth Offending Service completes a health assessment with all young people at risk of custody, and ensures that these assessments are accessed by the secure settings.

The **Street Prostitution Strategy in Ipswich** has demonstrated that providing generic worker support (social care) tailored to individuals enables them to access appropriate services. Taking individuals to mainstream clinics, such as dentists and sexual health clinics, and waiting with them has resulted in improved access and improved compliance. It has proved more successful than outreach without additional social support, where there was only a limited uptake of services.

The **Dawn Centre in Leicester** is a project for homeless people, providing temporary accommodation, support, advice and assistance on health, housing, life skills and education – all in one place.

The **Tough Choices** programme, a Home Office initiative, expands the Drug Intervention Programme (DIP). Police can test individuals on arrival for substance misuse, with positive results leading to a Required Assessment. This entails attending an assessment by a DIP worker to assess drug use and advise on an appropriate course of action. Failure to attend assessments is a criminal offence. Another element of this programme is the Restriction on Bail, whereby a court could impose a treatment requirement as a condition of bail.

Norwich Criminal Justice Liaison Scheme operates at Norwich Magistrates' and Crown courts, Bethat Street Police Station and HMP Norwich and HMP Edmunds Hill. It is the only scheme that Nacro is aware of that employs a full-time learning disability nurse. The scheme also has one RMN. The scheme operates four to five days per week and has good links with the YOT.

Hereford Youth Offending Team liaison with the Forensic Arrest Community Team (FACT): this initiative was developed by the health practitioner from Hereford Youth Offending Service and the local FACT leader. It is an informal arrangement, whereby the FACT representatives based within the police station contact the health practitioner if they have concerns about the emotional or mental health of a young person in police custody. The health practitioner reciprocates by passing on any information about 17- or 18-year-olds who are a cause of concern and who have come to the attention of the police. FACT representatives are not trained specifically to provide a service for young people, but the exchange of basic information allows those with such specialisms to become involved. Furthermore, should the individual reappear in police cells on a further occasion, FACT will be aware of any history of emotional or mental health problems and will be able to ensure that the relevant safeguards are put in place.

The **Wirral Criminal Justice Mental Health Liaison Team** operates at Birkenhead Magistrates' Court, Liverpool Crown Court and police stations in the Wirral. The team will also see Wirral residents at HMP Liverpool, HMP Altcourse, HMP Risley and HMP/YOI Styal. The team is made up of an approved social worker, a criminal justice CPN, a support worker and an administrator. It is jointly funded by social services and the NHS, and is based at probation offices, so it has good links with all parts of the CJS.

Sandwell Forensic Liaison Service operates with three forensic CPNs five days per week and is funded by the NHS Trust. It covers West Bromwich and Warley Magistrates' Courts and HMP Blakenhurst and HMP/YOI Brinsford. The scheme has in place good recording and monitoring procedures.

Birmingham, Coventry and Dudley Court Liaison Scheme operates at Birmingham, Coventry and Dudley Magistrates' Courts with a team of seven forensic CPNs and a forensic psychiatrist. The scheme is jointly funded and operates seven days per week.

Partners of Prisoners and Families Support Group (POPS) currently has a court project that places a family link worker in Manchester Magistrates' Court to support the accused's family members. This worker can access vital information on the accused's health condition and any mental health worries they may have. POPS believes that this should be considered by the sentencing panel before a decision is made.

West Midlands National Development Programme Pilot: as part of the National Development Programme, Revolving Doors is developing a pilot idea in the West Midlands at the Birmingham Community Justice Initiative (BCJI). Local stakeholders have identified a need for culturally sensitive primary care support workers to be based in the BCJI. The support service would offer flexible outreach to people with common mental health problems and multiple needs in the court.

The **Together (Working for Wellbeing) Forensic Mental Health Practitioner Service (FMHP)** currently operates three court liaison services in London (at Thames, Ealing and Feltham Magistrates' Courts) as part of a wider contract with London Probation in partnership with local PCTs and NHS Trusts. The service aims to:

- increase diversion of vulnerable offenders with mental health needs out of the CJS into healthcare services;
- provide appropriate and timely specialist advice to court;
- reduce inappropriate court requests for psychiatric reports (and reduce financial cost to the court);
- reduce the number of remands or length of time spent on remand of offenders with mental health needs; and
- facilitate appropriate sentencing outcomes.

The **Together (Working for Wellbeing) FMHP within London Probation:** Together (Working for Wellbeing), formerly known as the Mental After Care Association (MACA), is a national charity working for well-being. It supports people with mental health needs by: running a range of services across the country; campaigning and research; and educating local communities about their own mental health needs.

Together and London Probation started to look at how greater support could be made available to probation officers to understand and negotiate the complexities of inter-agency, multi-disciplinary working with mentally disordered offenders.

Through close partnership with London Probation and alongside colleagues in health and social services, the service aims to:

- improve the identification and assessment of mentally disordered offenders;
- ensure that offenders with mental health needs have access to the full range of community justice services so that, where possible, custodial sentences or inappropriate in-patient admissions are avoided;
- adopt proactive and practical approaches to joint work and co-ordination between criminal justice agencies, the local authority, primary and secondary mental health services, and drug and alcohol services, to reduce crime and improve mental well-being;
- enhance offender contact with and access of primary care services, particularly for vulnerable offenders who do not meet the thresholds for services for severe and enduring mental illness; and
- facilitate timely liaison between services in order to facilitate the end-to-end management of offenders.

The Together service has recently been reconfigured to take account of the potential impact on community mental health services of the introduction by the National Offender Management Service of the Offender Assessment System (OASys). Together, working with offender managers, now incorporates OASys into their offenders' mental health needs and risk assessments.

Plymouth Court problem-solving and advice desk: Devon and Cornwall Probation is a pilot area for Community Justice and has a problem-solving court and a community advice desk based in the foyer of Plymouth Court. This is based on the Red Hook/Liverpool/Salford Community Courts model. It has the potential to act together with health services to divert mentally disordered offenders either from the court process altogether or to appropriate sentences backed up by suitable resources. The Ministry of Justice heads up the community justice programme. NHS staff also form a core membership of the LCJB in Devon and Cornwall, which is a rarity. The service has been cited as an example of good practice of how to co-ordinate policy and practice for mentally disordered offenders.

At **Manchester City Magistrates' Court** a CPN is made available to speak to potentially mentally disordered offenders in the cells. They are normally alerted to these defendants by guided skills learning officers.

The South West Court Mental Health Assessment Pilot based at Bristol Magistrates' Court utilises money from courts to pay two CPNs to provide immediate/speedy sentencing advice linked to local service provision. This has established a model that can be replicated in other parts of the South West Region Public Protection Pathfinder Project.

Part 4: Prisons and rehabilitation

Question 48 – Do you have any examples of good practice that can be cited in the main strategy?

The **Therapeutic Behavioural Specialists system in Holland** provides for indeterminate detention for an offender convicted of an offence carrying a maximum penalty of four or more years, who has impaired mental faculties and is judged to be a grave risk to the public.

HMP Bronzefield works with Women In Special Hospitals, providing them with support in preparation for release and continued support in the community. It also jointly funds an in-house midwifery service with Surrey PCT. It also has the Help and Direction Unit as a step-down facility for prisoners from healthcare and runs a day centre, which is open to prisoners with vulnerabilities on normal location. It has built a pharmacy and consulting room on the detoxification unit. The detoxification nursing team is based on the unit and the Counselling, Assessment, Referral, Advice and Throughcare service holds a drop-in facility which is based on the unit. The programmes team delivers a sexual health awareness programme with volunteers from local agencies, to provide information to prisoners involved in prostitution.

HMP Peterborough has the Bridge Centre, a holistic therapies programme offering a wide range of holistic and beauty therapies which effectively reduce stress levels and improve self-esteem. The training has led to employment opportunities upon release. There are good links with drug rehabilitation and mental health teams, who refer clients for therapy sessions. Other workshops include a writing group, yoga, an insomnia group, feng shui, sound therapy, a music workshop and Spanish.

HMP/YOI Forest Bank in Manchester has sexual health clinics which are provided by the PCT, and the PCT also trains staff. The prison has also built a supply kitchen and restaurant, where prisoners are trained as chefs and waiters. They work with the Radisson Group and deliver the same menus.

One afternoon a week, the **Rotherham YOS** held a drop-in for children and young people associated with the YOS. The health worker was one of the specialist staff from the resource team who was available on a non-appointment basis to give advice and support. A significant number of children and young people used this session to request help from the health worker on issues including emergency contraception and sexual health. Accommodation and training advice were also offered by specialist staff.

HMP Liverpool has a single point referral meeting, which includes agencies both within the prison and across Merseyside. A primary care psychological service has also been established within the prison, enabling the same provider between prison and the community (i.e. across the gate) for offenders who have primary care mental health needs.

The **mental health in-reach teams** in HMP Littlehey, HMP Whitemoor and HMP Peterborough are in situ and operate in a very similar way to community mental health teams. The continuous presence of the teams promotes greater integration and speedier provision of services.

The National AIDS Trust publication *Tackling Blood Borne Viruses in Prisons – A framework for best practice in the UK* (2007b) emphasises the importance of engagement from all sectors involved in prison health. The document was developed with the assistance of an expert working group made up of prison staff, voluntary sector staff, clinicians and government representatives. The framework is an example of good partnership working on healthcare in prisons. A recent evaluation of the framework achieved excellent results, with two-thirds of prisons implementing changes to their practices as a result of framework recommendations. The framework also contains examples of good practice taken from prisons. For example, it gives details of an in-reach service provided by the Terrence Higgins Trust to HMP Wandsworth, offering one-to-one support and information sessions for prisoners on sexual health, relationships and HIV. The document can be accessed online at www.nat.org.uk/document/255

The resettlement wing at **HMP Wormwood Scrubs** has brought together agencies working in the community and prison to form an effective partnership.

In **Red Bank Community Home** in Merseyside, five out of seven young offenders in one section had a learning difficulty and displayed challenging behaviour. Staff were on average involved in physically restraining these young offenders on two to three occasions every day. After receiving communication training and guidance from a speech and language therapist, the staff were able to reduce the number of restraints used to two per week.

The **New Futures Health Trainers** project trains prisoners and ex-offenders on probation to be able to signpost their peers into health services and/or offer behaviour change advice and support. An impact assessment by Brooker and Sirdifield (2007) showed that this scheme has a very positive influence on the individuals trained as health trainers, as well as improving access to services by some offenders who were on probation or in custody. Offenders who undertake this training may then have the potential to be able to work in other areas of the health field.

The **Prison Mental Health In-Reach Team** operating in **HMP Leeds and HMP Wealstun** provides a comprehensive service to offenders with serious mental health problems. In March 2007, when the Second National Survey of Prison In-reach was conducted (Brooker et al., 2008), the team had eight members of clinical staff plus one support worker and one member of admin staff, thus being one of the largest such teams in England. Two members of that team have been trained in cognitive behavioural therapy and another two in psychosocial interventions, providing psychotherapeutic input into the treatment of service users on their caseload. The team's operational policy clearly spells out the criteria for good service provision. There is integration with the primary mental healthcare team, which operates through a single mental health referral point, and regular joint CPA meetings, exemplifying well co-ordinated mental healthcare available to service users in these two prisons.

Diversity House is a voluntary sector organisation providing community and prison-based services for minority communities, particularly with drug and alcohol issues, across Kent. It offers a holistic and person-centred package of care for service users on issues such as building bridges with family, debt management, housing, mentoring and counselling services. Within the Kent local prisons they provide wraparound services for offenders from minority communities, to ensure continuity of services provided to prevent re-offending upon release into the community.

The **Oxfordshire Child and Adolescent Forensic Team** is located within core mental health provision for children and adolescents at Oxfordshire Mental Healthcare NHS Trust and is funded by prison in-reach monies and Oxfordshire YOT. There are service-level agreements with local PCTs for mental health in-reach to HMYOI Huntercombe and also with the YOT.

HMYOI Huntercombe 'Healthy Huntercombe Project': Huntercombe is a prison for sentenced juveniles aged 16 to 18 years old. The prison has carried out a healthy schools audit and has identified some action points to take forward. Huntercombe's work compares favourably with progress made by secondary schools in Oxfordshire. They have noted a gap in the provision of therapeutic interventions that support young people to manage their feelings and behaviour, self-esteem and confidence. Programmes introduced as a result include sexual health training provided by the Terrence Higgins Trust, and smoking cessation services provided on a one-to-one basis which have proved more effective with young smokers. There will be a chlamydia screening programme for all new arrivals and there are plans to start a cannabis awareness group. Officers are to be encouraged to sit with young people during lunchtime as routine practice, to encourage positive social interaction at mealtimes. Young people have access to free-phone ChildLine through the telephone system. A special early evening 'non-attenders' session is run at the gym at 17.00 each day, to ensure that vulnerable young people who are reluctant to join core PE sessions have the opportunity to participate in physical exercise. There are several young people's forums: a monthly young people's forum; a diversity group; and a physical education forum. The mental health team offers dialectical behavioural therapy on a one-to-one basis to help vulnerable young people develop skills to cope and manage harmful behaviour.

HMP Downview is a prison for sentenced females but also has a 16-bed juvenile unit: the **Josephine Butler Unit**. The healthcare centre in the prison has piloted 'Weight busters', which is a 12-week course. It has run three groups and all the women have successfully lost weight. The group encourages healthier lifestyles and increased self-esteem, by educating women about diet and giving them a pedometer and a diary to record what they have eaten and how many steps a day they have walked. This programme has led to increased detection of diabetes and high blood pressure. The programme will be adapted for HMP High Down. A Foreign Nationals Forum runs monthly and there is an opportunity for women to raise healthcare issues at this forum. The community development worker has been carrying out a review of BME women in Downview, High Down and the Josephine Butler Unit, which highlights the limited support in place for prisoners with mental health needs from BME and foreign national communities. Mental health in-reach assessment forms and ethnic monitoring are being reviewed. A voluntary sector directory has been created, to enable mental health staff to refer clients to culturally appropriate community support on discharge. A BME and foreign national mental health prison group has been established. Newsletters have been produced for BME and foreign national prisoners, focusing on mental health issues, and mental health information leaflets will be provided in different languages. Proposals have been put forward for meaningful activities including a cultural diversity workshop, movement therapy and counselling. Hibiscus (Female Prisoners Welfare Project) will be starting a counselling service for foreign national prisoners, and information about this service will be distributed to prisoners in a well-being newsletter.

A tuberculosis nurse is in place at **HMP Pentonville** in London, who ensures good links with the community and continuity of care. This service will also be expanding into **HMP Wormwood Scrubs**, which will provide a comprehensive infectious disease care service.

Based at **HMP Winchester**, the Wessex project is a multi-agency team including probation and health staff. They are responsible for individuals at remand stage and ensure that an efficient CPA is completed.

The South West Prison Health Development Team and Regional Public Health Group has established a project to support prisons in the region to implement smoke-free legislation. The Prison Service Instruction (PSI) requires prisons to undertake health and safety risk assessments, designate cells as smoking or non-smoking, ensure that non-smokers do not share cells with smokers, and provide adequate levels of support to stop smoking. A South West Prisons and Smoking Working Group, consisting of stakeholders from the Prison Service, the NHS and local authorities, has been set up to take the work forward. A baseline survey of prisons was undertaken in the summer of 2007, to identify progress in implementing the PSI and barriers to its implementation. The survey findings are being presented to all prison and PCT partnership boards in order to encourage enhancement of smoking services for prisoners, to ensure that all prisoners who wish to make a quit attempt are supported to do so. Discussions with partnership boards are also aimed at identifying ways of raising awareness of the adverse health impacts of smoking and exposure to second-hand smoke. Some successes have been achieved in the South West, with a commitment to increased delivery of support to stop smoking services and designation of hospital cells as non-smoking in some prisons. Agreement has been reached to train integrated drug treatment system staff at two prisons to deliver support to stop smoking, as part of developing an integrated approach to substance misuse and increasing capacity within prisons to deliver smoking support. A pilot of visitor centres is being set up to trial workshops aimed at encouraging partners and families of prisoners to make an attempt to stop smoking, and to raise awareness among families and prisoners of the impact of second-hand smoke on children. The working group is also developing a range of tools to assist prisons in implementing the PSI, including a model smoking policy, a health and safety risk assessment tool, and a needs assessment tool to assist in planning services.

Part 5: Probation, release and resettlement

Question 59 – Do you have any examples of good practice that can be cited in the main strategy?

Penrose Housing Association, London has developed a health promotion strategy in partnership with service users. This was initiated after individuals wanted to find out about additional ways to take control of their health and well-being. It details the impact of interventions that individuals can be encouraged to pursue independently, such as exercise, nutrition and building social capital. Penrose runs regular sports and leisure groups. It has found that sport is a very effective way to engage its service users in the first instance. Once they are engaged, the additional benefits of developing social capital and the impact of positive nutrition can happen naturally. This scheme can also provide a platform for individuals to access information, advice and guidance around PCT initiatives. Complementary therapies, including acupuncture and meditation, have been successful in engaging and empowering individuals.

West Yorkshire Community Chaplaincy Project works with prisoners from HMP Leeds prior to and on release to support with debt, housing, employment, etc. They aim to reduce re-offending rates for prisoners leaving HMP Leeds using a specialist team and existing relevant agencies, and by proactively involving multi-faith communities.

The Jigsaw Visitors Centre based at **HMP Leeds** is a healthy living centre which works with prisoners' families, prisoners, prison staff and the local community.

Patient Advice and Liaison Services provide information regarding health services, offer guidance and support around care and will signpost to health services. PALS have a dedicated dental helpline, providing a pathway upon release into the community.

Nacro's Onside, Onside 2 and Milestones projects are three phases of a resettlement programme for young males in **Portland YOI**. Each phase aims to steer young people away from a life of crime by offering help with practical problems. The projects have been evaluated, and participants had a reconviction rate of 60% compared to the national reconviction rate for juvenile prisoners, which at the time was 84%. Post-release contact between client and project worker was a statistically significant factor in reducing reconviction rates, with 39% of those who maintained contact being reconvicted, compared to 73% of those who did not maintain contact. Of the young men on the Onside 2 project, 46% had a mental health issue requiring some form of support or intervention. Almost a quarter had self-harmed at some point in their lives and at least 15% had attempted suicide. Some 87% had been dependent on drugs or alcohol or had used them problematically at some point in their lives. Case notes cited in the evaluation indicate that young men suffered from depression, paranoia, drug-induced psychosis and panic attacks. After release, project workers put young people in contact with services that they would not easily have been able to access on their own, for example the support of a CPN.

The **Steps to Work Programme** was pioneered in one of the **Isle of Wight prisons** by the charitable organisation Wight Employment Christian Action Network (this charity no longer operates). Working with prison educational staff, specially recruited personnel ran the programme in conjunction with their work across the island. This seemed to be valuable as a lever for rehabilitation, as links were made with those outside the prison system.

The **University of Lincoln** has recently worked in partnership with staff from the National Probation Service and local mental health services to produce a mental health awareness training course designed specifically for probation staff. This will shortly begin to be delivered across the East Midlands region through a 'train the trainer' model. The course includes an introduction to a number of mental health disorders and is aimed at all probation staff, with suggested 'stepping off' points for different staff grades. It will be evaluated across the East Midlands. Ideally, this training will be mandatory for all probation staff, to ensure that they have a level of mental health awareness and feel confident to work with mentally disordered offenders. The University of Lincoln is also undertaking a health needs assessment of offenders in the community in two probation areas of the East Midlands. The project aims to examine the healthcare needs of an urban and a rural probation population; compare the health profiles of offenders on probation caseloads with the general population; and examine the extent to which offender populations are addressing their healthcare needs and accessing services.

The residents of **Kew Hostel** in Surrey are men who have served long-term prison sentences for serious, often violent, offences. The primary care needs of this client group are historically higher than average, with particularly increased need for mental health services. Owing 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 GP practice and the GP surgery's registered population. The PCT recognises that additional support is needed to ensure the registration of these residents, their appropriate access to services, and the appropriate level of support and structure to the practice. Therefore, the following service specification has been agreed for approved premises, to facilitate the provision of services by a contracted GP practice.

Functions of approved premises include:

- to contribute to the protection of the public from those who pose the most serious risk of harm;
- to contribute to the assessment of offenders using the Offender Assessment System (OASys) and other approved assessment tools;
- to contribute to the delivery of risk management plans, including those agreed with the MAPPA;
- to provide a regime of 'enhanced supervision', together with other measures when necessary, in the interests of public protection;
- to provide a planned, structured regime of interventions, including one-to-one key working, derived from the offender manager's sentence/supervision plan and underpinned by pro-social modelling and motivational principles;
- to deliver, or contribute to the delivery of, effective treatment programmes, including relapse prevention work; and
- to co-ordinate a range of services (to include health, education, life skills, employment and resettlement services) in the interests of effective rehabilitation, as determined by the offender manager's sentence/supervision plan.

The **Bracton Centre Forensic Mental Health Service** has been providing a consultation service to probation hostels in London over the past 15 years. Until 2005, this provision was funded by the Inner London Probation Service. The aim was for the London Probation Area and the Bracton Centre to form a partnership providing specialist hostel provision for high-risk personality disordered offenders. The partnership aimed to bridge the gap between mental health and criminal justice services for a group of individuals who were at high risk of social exclusion owing to their challenging behaviour and psychological needs. Since 2005, there has been a change in national probation policy and practice with regard to hostel provision. Currently, the majority of the 13 approved premises for the London Probation Area are required to consider and accept higher-risk offenders, including those with marked personality difficulties. This has highlighted the need to move away from a specialist type of provision to a more standard collaborative approach between mental health services and the approved premises. The preferred model is one of consultation and liaison from local services with low-level support, across all hostels. To date, the regular forensic mental health provision to London Probation Area approved premises, other than in the Bracton Centre catchment area, has been variable.

The Bracton Centre catchment area includes three hostels, each of which poses slightly different issues for a consultation model:

- Hostel A has clearly been used to a reasonably high level of support from the Bracton Centre over the past decade;
- Hostel B has received Bracton Centre psychology input over a number of years but now also has access to the Southwark Forensic Community Mental Health Outreach Team, which facilitates greater access to forensic psychiatry and forensic community psychiatric nursing under the auspices of the South London and Maudsley NHS Foundation Trust; and
- Hostel C had no history of regular consultation and input from the Bracton Centre until 2005, and a limited and rather strained relationship with local mental health services.

The aim of the consultation and liaison model has been to provide support to the Probation Service in managing residents with mental health problems and personality dysfunction, and those posing a high risk of re-offending. This consultation model has been of primary importance in bridging the gap between mental health and criminal justice services, and has led to the development of a screening tool that may assist non-mental health staff in identifying mental health need in hostel residents.

Kent Probation Service jointly runs a group with West Kent Learning Disabilities Team for men with learning disabilities who have convictions for sexual offences. The group members are referred by both agencies.

The Ladywood Scheme in Birmingham is a good example of police, probation and health services working together to tackle drug-related crime. The scheme recognises the importance of getting offenders off drugs as soon as possible after arrest. The Community Drug Referral Team fast-tracks referrals from the Ladywood Scheme, and offenders are seen by probation partnership drugs workers. This process starts soon after arrest. In suitable cases, offenders are then made subject to Community Orders with drug treatment requirements attached. The purpose of the scheme is to check whether offenders are telling the truth about their abstinence from drugs.

Section 2 – Making it happen

Part 3: Provider development and support

Question 76 – Do you have any examples of good practice that can be cited in the main strategy?

Suffolk Coastal Council and the charity **Coastal Homeless Action Group (CHAG)** have teamed up, with the council agreeing to take the lead in housing advice and prevention of homelessness and CHAG concentrating on supporting people to live independently. It has been very useful for PPOs when they have had difficulty in keeping tenancies.

RiO information system is a web-based product used in the NHS, accessible via a secure internet connection. It has been reported as being easy to use and has combined features from several other systems, making it practical. The software is built on a series of straightforward forms that can capture data for assessments, care plans and clinical recording. RiO can be used to produce reports which collate information from around the system and present data in different ways, even generating letters and emails automatically. The reports can link directly to different areas of the patient's record to give more background information.

Greater Manchester has been piloting an information service and active multi-agency assessment for some time. In **Wales**, a smaller-scale information-sharing hub is being developed in support of the multi-agency strategic assessment to inform the local service board.

Gwent Police has already begun to use a data miner that could potentially extract data from a variety of multi-agency systems. The click view system is fairly new to the policing organisation and could be worthy of further study in this context.

The baseline survey of prisons undertaken by the **South West Prisons and Smoking Working Group** highlighted that most prisons do not use the data collected on reception during medical assessments, or during cell share risk assessments, to assess need and plan services. The working group is developing guidance to assist prisons in undertaking smoking support needs assessments.

Across the East of England most prisons are currently implementing **SystmOne** (supplied by CSC) as part of the Connecting for Health Programme. Use of the system has enabled production of secure and instantly accessible healthcare records, efficient administrative management of appointments, as well as monitoring of healthcare provision through reporting. Not only do prisoners have a rapidly accessible record, but this can be electronically transferred to the next organisation that the prisoner moves on to. This provides a safer approach to treating patients, with fuller information available, as well as the efficiency savings of transferring records as opposed to recreating them. If all prisons used the same clinical system, notes would not need to be printed to send with the prisoner to court if the prisoner were transferred, their records could 'travel' with them to the next establishment, etc.

Part 5: Service user involvement

Question 85 – Do you have any examples of good practice that can be cited in the main strategy?

Penrose Housing Association's health promotion strategy was initially developed in response to service users' requests for additional ways for them to manage their own health. Some individuals have felt disempowered in their previous experiences of accessing healthcare, sometimes feeling that services are forced upon them, or that services appropriate to their need are difficult to find.

Liverpool Primary Care Trust is establishing a presence within the service user forum of a local day centre for homeless people. The day centre has established a relationship with the service users and is trusted by them, so the PCT is getting a lot of information that it would not otherwise hear.

Appendix 3: Journal articles/documents referred to in respondents' replies

Anthony, W. A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990s, *Psychosocial Rehabilitation Journal*, **16**, 11–23

Audit Commission (2007) *Healthy competition.* www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=D8FF4C6D-C465-4f81-9052-C18A0C16E83C

Audit Commission (2007) *Hearts and minds: Commissioning from the voluntary sector.* www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=418C38AF-0D97-49dd-95D6-EE7E7BA43773

Audit Commission (2008) *For better, for worse: Value for money in strategic service-delivery partnerships.* www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=ENGLISH^576^SUBJECT^488^REPORTS-AND-DATA^AC-REPORTS&ProdID=2EC60F18-BDC2-4faf-98AC-2E495B8B6CBD

Bennett, J., Kalathil, J. and Keating, F. (2007) *Race equality training in mental health services in England: Does one size fit all?* London: The Sainsbury Centre for Mental Health

Brooker, C. and Sirdifield, C. (2007) *New futures health trainers: An impact assessment.* www.lincoln.ac.uk/cjmh/docs/OHTR_final2.pdf

Brooker, C., Gojkovic, D. and Shaw, J. (2008) *The Second National Survey of Prison Inreach.* London: DH

Care Services Improvement Partnership (2007) *Positive practice – positive outcomes: A handbook for professionals in the criminal justice system working with offenders with learning disabilities.* London: CSIP. http://kc.csip.org.uk/viewresource.php?action=viewdocument&doc=98519&grp=1

Crown Prosecution Service (2006) Consultation on 'Policy for prosecuting cases involving sexual transmission of infections which cause grievous bodily harm'. London: CPS

Department for Education and Skills (2003) *Every child matters* (Cm 5860). London: HMSO.

Department of Health (1999a) *Drug misuse and dependence – Guidelines on clinical management.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009665

Department of Health (1999b) *The future organisation of prison health care.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006944

Department of Health (2004) *Standards for better health.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

Department of Health (2005) *Delivering race equality in mental health care: An action plan for reform inside and outside services and The Government's response to the independent inquiry into the death of David Bennett.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Department of Health (2007a) *Valuing people now: From progress to transformation.* London: DH. www.dh.gov.uk/en/Consultations/Liveconsultations/DH_081014

Department of Health (2007b) *World class commissioning: Vision.* London: DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956

Department of Health (2007c) *Improving access to psychological therapies (IAPT) programme.* London: DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073470

Department of Health (2007d) *A pathway to care for older offenders: A toolkit for good practice.* London: DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928

Department of Health (2007e) *Guidance on joint strategic needs assessment.* London: DH. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

Digard, L., Grafin von Sponeck, A. and Liebling, A. (2007). All together now: The therapeutic potential of a prison-based music programme. *Prison Service Journal,* **170**, 3–14

Downes, R. and Job, N. (2007) *Volatile substance abuse: A training manual.* National Children's Bureau.

Durcan, G. and Knowles, K. (2006) *Policy paper 5: London's prison mental health services: A review.* London: The Sainsbury Centre for Mental Health

Farrell, M. and Marsden, J. (2008) Acute risk of drug-related death among newly released prisoners in England and Wales. *Addiction,* **103**(2), 251–5

Fawcett Society (2001) *Joining up services for women offenders at a local level: Report from the Gender and Justice Policy Network Seminar.* London: Fawcett Society

Gelsthorpe, L., Sharp, G. and Roberts, J. (2007) *Provision for women offenders in the community.* London: Fawcett Society

Halliday, K. (2007) *Community primary care access for offenders in the West Midlands region.* www.westmidlands.csip.org.uk/silo/files/primary-care-access-exec-summary.pdf

Hamlyn, B. and Lewis, D. (2000) *Women prisoners: A survey of their work and training experiences in custody and on release.* London: Home Office

Healthcare commission annual health check. www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck.cfm

Health Protection Agency (2006) *Shooting up: Infections among injecting drug users in the United Kingdom 2005*. London: Health Protection Agency. www.hpa.org.uk/cdr/archives/archive06/News/news4306.htm

Henggeler, S. et al (1999) Home-based multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: clinical outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, **38**(11), 1331–9

Her Majesty's Inspectorate of Prisons (2004) *No problems – old and quiet: Older prisoners in England and Wales.* http://inspectorates.justice.gov.uk/hmiprisons/thematic-reports1/hmp-thematic-older-04.pdf

Her Majesty's Inspectorate of Prisons (2005) *Parallel worlds: A thematic review of race relations in prisons.* http://inspectorates.justice.gov.uk/hmiprisons/thematic-reports1/parallelworlds.pdf

Her Majesty's Inspectorate of Prisons (2007) *The mental health of prisoners: A thematic review of the support and care of prisoners with mental health needs.* http://inspectorates.homeoffice.gov.uk/hmiprisons/thematic-reports1/Mental_Health.pdf

Her Majesty's Inspectorate of Prisons (2008) *HM Chief Inspector of Prisons for England and Wales: Annual report 2006–2007*. http://inspectorates.homeoffice.gov.uk/hmiprisons/docs/prisons_ann_rep_06-07.pdf?view=Binary

Her Majesty's Stationery Office (2002) *The Local Authority Remands (Electronic Monitoring of Conditions) (Responsible Officer) Order 2002*. London: HMSO. www.opsi.gov.uk/si/si2002/20020845.htm

Home Office (2002) *Assessment report on the Kent Custody Nurse Scheme*. London: Home Office. http://police.homeoffice.gov.uk/publications/operational-policing/gannon_report.pdf

Home Office (2004) *Women's Offending Reduction Programme action plan*. London: Home Office. www.homeoffice.gov.uk/documents/WORP-action-plan

Home Office (2007) *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system.* www.homeoffice.gov.uk/documents/corston-report

Hough, M., et al. (2003) *The impact of drug treatment and testing orders on offending: Two-year reconviction results*. London: Home Office. www.homeoffice.gov.uk/rds/pdfs2/r184.pdf

MacAskill, S., and Hayton, P. (2007) *Stop smoking support in HM prisons: The impact of nicotine replacement therapy*. Department of Health, HM Prison Service, The Open University and University of Stirling.

McBrien, J. A., Hodgetts, A. and Gregory, J. (2003) Offending and risky behaviour in community services for people with intellectual disabilities. *The Journal of Forensic Psychiatry & Psychology*, **14**(2), 280–97

McSweeney, T. and Hough, M. (2005) Drugs and Alcohol, in Tilley, N. (Ed) *Handbook of Crime Prevention and Community Safety.* Cullompton: Willan

Ministry of Justice (2008) *Strategic plan for reducing re-offending 2008–11: Working in partnership to reduce re-offending and make communities safer*. London: Ministry of Justice

Nacro (1998) *Children, health and crime: A report by Nacro's Committee on Children and Crime.* London: Nacro, Government Office for the South West (currently unpublished)

Nacro (2000) *The forgotten majority: The resettlement of short-term prisoners.* London: Nacro

Nacro (2001) *Women who challenge: Women offenders and mental health issues.* London: Nacro

Nacro (2004) *Findings of the 2004 survey of court diversion/criminal justice mental health liaison schemes for mentally disordered offenders in England and Wales.* London: Nacro

Nacro (2005) *Liaison and diversion for mentally disordered offenders.* London: Nacro

Nacro (2007) *Effective mental healthcare for offenders: The need for a fresh approach.* London: Nacro

National AIDS Trust (2007a) *Commissioning HIV prevention activities in England.* www.nat.org.uk/document/384

National AIDS Trust (2007b) *Tackling blood borne viruses in prisons – A framework for best practice in the UK.* www.nat.org.uk/document/255

National Audit Office Report (2004) *The drug treatment and testing order: Early lessons.* London: The Stationery Office. www.nao.org.uk/publications/nao_reports/03-04/0304366.pdf

National Centre for Policing Excellence on behalf of the Association of Chief Police Officers (2005) *Guidance on the National Intelligence Model*. London: ACPO. www.acpo.police.uk/asp/policies/Data/nim2005.pdf

National Treatment Agency (2004) *Engaging and retaining clients in drug treatment.* Research Into Practice 5. London: National Treatment Agency for Substance Misuse

NHS Primary Care Contracting (2007) *Primary care service framework: Management of health for people with learning disabilities in primary care.* London: NHS. www.primarycarecontracting.nhs.uk/uploads/primary_care_service_frameworks/primary_care_service_framework__ld_v3_final.pdf

Plugge, E., Douglas, N. and Fitzpatrick, R. (2006) *The Health of Women in Prison Study.* Oxford: University of Oxford

Prison Reform Trust/National AIDS Trust (2005) *HIV and hepatitis in UK prisons: Addressing prisoners' healthcare needs.* www.nat.org.uk/document/105

Sainsbury Centre for Mental Health (2007) *Getting the basics right: Developing a primary care mental health service in prisons.* London: The Sainsbury Centre for Mental Health

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making recovery a reality*. London: The Sainsbury Centre for Mental Health

Singleton, N. et al. (1998) *Psychiatric morbidity among prisoners in England and Wales.* London: Office for National Statistics

Singleton, N., Farrell, M. and Meltzer, H. (1999) *Substance misuse among prisoners in England and Wales.* London: Office for National Statistics

Tarlov, A.R. et al. (1989) The medical outcomes study: An application of methods for monitoring the results of medical care. *Journal of the American Medical Association*, **262**, 925–30

Train to Gain. www.traintogain.gov.uk

Turning Point (2007) *At the sharp end: A snapshot of 21st century injecting drug use.* London: Turning Point

United Nations (1989) Convention on the Rights of the Child. http://untreaty.un.org/English/TreatyEvent2001/pdf/03e.pdf

Young, S., Gudjonsson, G.H. and Needham-Bennett, H. (2005) Multi-agency public protection panels for dangerous offenders: One London forensic team's experience. *Journal of Forensic Psychiatry and Psychology,* **16**(2): 312–27

Youth Justice Board (2005) *Strategy for the secure estate for children and young people.* www.yjb.gov.uk/publications/Resources/Downloads/YJB_Strategy_Secure_Estate.pdf

Youth Justice Board. Professional certificate in effective practice. www.yjb.gov.uk/en-gb/practitioners/WorkforceDevelopment/ProfessionalCertificateinEffectivePractice/

Youth Justice Board. ASSET. www.yjb.gov.uk/en-gb/practitioners/Assessment/Asset.htm

Ward, T. Human rights and correctional clinical practice. *Aggression & Violent Behavior.* In Press

Ward, T. and Maruna, S. (2007) *Rehabilitation.* London: Routledge

Wilson, D. and Logan, M. (2006) *Breaking down walls. The Good Vibrations Project in prison.* www.apcentre.org.uk/assets/ap/001/Breaking%20Down%20Walls%20report%20final%20version%20_2_%20_3_.pdf

289381 August 08
Produced by COI for the Department of Health
www.dh.gov.uk/publications