Rebalancing Act

A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users.

Home Office

Public Health England

Lankelly Chase

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Revolving Doors is a national charity that has been working for over 20 years to change systems and improve services for people facing multiple disadvantage and stuck in the revolving door of crisis and crime. We bring independent research, service evaluation, policy and lived experience together to support effective solutions for the 'revolving doors' group. These are people who are in contact with the criminal justice system and face multiple disadvantage, including mental ill health, substance misuse, domestic abuse and homelessness. We work to reform services, and improve support and outcomes for this group. We do this by working with policymakers, commissioners and service providers, and through reflecting lived experience in everything we do. We act as a trusted critical friend to government departments, local authorities and service providers across the public and voluntary sectors.

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Foreword

People in contact with the criminal justice system (CJS) include those in prison and other prescribed places of detention as well as those living in the wider community. There are for example offenders serving community sentences; those in the community on licence, and those 'known to the police'. Nearly 2 million people a year in England have contact with police forces resulting in a record on the Police National Computer (PNC). Among this population are many who experience significant issues with health problems (including physical and mental health and substance misuse) which are often complicated by social issues such as unemployment, indebtedness, homelessness or social isolation. We describe such people as having "multiple and complex needs" which means typically that no one agency or organisation working alone can address those needs. Further, there are often strong links between such needs and offending/ reoffending behaviour - so reducing criminal behaviour and improving community safety can be an outcome of addressing these health and social care needs. Finally, people in contact with the CJS often experience significant health inequalities: a higher burden of disease and less access to health services, including preventive services. Addressing the health needs of this population can contribute to reducing inequalities in wider society.

In 2013, Revolving Doors Agency, working with Public Health England and the Probation Chiefs Association, published *Balancing Act- A briefing for Directors of Public Health: Addressing health inequalities among people in contact with the criminal justice system*. Directors of Public Health (DsPH) not only have a legal duty to address health inequalities experienced within their local authority boundaries, but also have a strong track record of good practice and innovating in this area. However, people in contact with the CJS were often not 'visible' in Joint Strategic Needs Assessments or Health and Wellbeing Strategies published by DsPH although clearly were among groups included among those experiencing health inequalities. "Balancing Act" was an attempt to improve the visibility of this group and support DsPH in developing evidence-based health and social care needs assessments. Developments in recent years have added to the responsibilities of DsPH, and have created new partners who, we believe, have a common interest in addressing health inequalities among people in contact with the CJS. Chief among these are Police and Crime Commissioners (PCCs), and police services, as there is a growing recognition of the associations between health and social inequalities, and offending and reoffending. Therefore, we realised a need to 'rebalance' our approach - recognising PCCs, police forces and other criminal justice agencies as key partners in addressing health inequalities as well as the role of health agencies in reducing reoffending by addressing health-related drivers of criminal behaviour.

This new resource, Rebalancing Act, is therefore intended to support a broad range of stakeholders at local, regional and national level, to understand and meet the health and social care needs of people in contact with the CJS and through this engagement reduce offending and improve community safety.

We appreciate that those who commission or provide public services are operating under tight financial constraints. In this call for action, we are not asking people to develop new services where none existed before but rather we are hopeful that through changes such as collaborating effectively, sharing information, or even through pooling funding, it will be possible to deliver services that are not only more efficient and effective, but

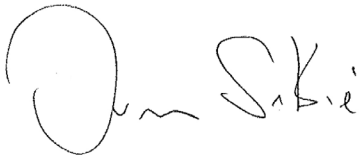
also more cost effective. For some of the individual interventions included here, such as substance misuse treatment, there is already strong evidence of a positive return on investment. For others, the evidence base is less developed. Therefore, it will be important to build evaluation into new ways of working to enable us to 'learn by doing' and inform future developments. However, it is not just about delivering services; it is also about developing programmes which take a public health approach, such as tackling 'the causes of the causes'. For example, tackling homelessness and housing problems, worklessness and poverty, which are all too prevalent in this group.

We hope that this resource will stimulate local interest, and act as a catalyst for local action by offering a brief overview of:

- the key health inequalities experienced by this population;
- some of the associations between health and social care needs with offending and reoffending behaviour; and
- identifying some of the key stakeholders at a local level who can come together to address these needs.

For this to work, the essential ingredients are a clear vision of what is to be achieved; strong leadership at local level, and effective collaboration across not only health and justice organisations but also local government and third sector organisations. Most of all, we have to ensure that we put people at the centre of our plans- those who offend, those who are victims of crime, and the needs of the whole community.

Christina Marriott
Chief Executive of Revolving Doors Agency



Duncan Selbie
Chief Executive, Public Health England

Executive summary

This resource is structured around the themes of policy; prevalence; and partnership and governance. In adopting this approach, we have tried to provide an introduction to the context, the need for action, and to highlight some of the activity being undertaken now in local areas to try to address some of the challenges outlined here.

The prevalence of health and social problems among those in contact with the CJS is high. This resource draws on a range of published data to illustrate this, and in doing so highlights one of the biggest obstacles in any attempt to redesign systems at a local level. Much of the data is incomplete, out of date, unpublished, or otherwise problematic. It is also widely dispersed, across Government statistical releases and reports, academic journals, and a host of other stakeholders including the police, probation, Jobcentre Plus, health services and local authorities.

This highlights the importance of partnership. Due to the limited and fragmented data and intelligence, we argue that partnership is central not only to the place-based delivery of services but also to the place-based assessment of need and planning of services. While the need to break out of system siloes has long been understood, the introduction of PCCs and other recent changes, such as devolution deals, may facilitate moves towards this through moving decisions and, crucially, funding to a local level. While these new flexibilities are to be welcomed, this must be tempered with the realisation that public services are operating under serious financial constraints, and that it appears likely that this will remain in the case for the foreseeable future.

This resource, of necessity, can only provide a quick tour of some of the most salient factors. This is, in part, due to the wide audience it is written for, which includes:

- Police and Crime Commissioners
- Directors of Public Health
- Clinical commissioning groups
- NHS England Health and Justice Commissioners
- HM Courts and Tribunals Service
- Prison governors
- Local authority members
- Directors of housing
- Directors of adult social care
- Directors of children's and family services
- Directors of education
- Community Rehabilitation Companies and the National Probation Service
- Chief police officers and police services
- Voluntary and community sector
- Jobcentre Plus managers and providers of labour market programmes
- User and family representatives

Once stakeholders have been identified and engaged, the call is for the following, straightforward approach to services and systems to be adopted, based on the Shewhart cycle of continuous improvement: plan, do, check and adjust:

- build understanding of the specific health needs of people in contact with the criminal justice system locally;
- engage with communities, including service users and those with lived experience;
- commission and deliver programmes jointly with partners across the system, including developing early intervention and prevention programmes; and monitor and evaluate progress and change.

The intention is that Rebalancing Act will be the first of a suite of documents; further briefings will provide the opportunity to give further consideration to matters such as NHS sustainability and transformation plans and commissioning.

Introduction

The links between inequalities, social exclusion and involvement in the criminal justice system are complex. Addressing inequalities, including health inequalities, as well as directly addressing offending behaviour can improve public safety, prevent offending and reoffending, and reduce crime. Furthermore, meeting the health and social care needs and reducing the inequalities highlighted in this briefing will also help to improve outcomes for other people, including those not in contact with the criminal justice system – the community dividend.

The UK spends around £15bn per year on the criminal justice system – providing police services, the Crown Prosecution Service, through to courts, probation and prisons. The financial costs of crime are tremendous, and the personal and social costs often calamitous for the places and people affected. This situation is unsustainable.

The health, economic and social inequalities faced by the population in contact with the criminal justice system are stark and striking. While evidence is of variable quality, the picture that emerges is one of a population characterised by high levels of health needs, housing problems, not being in employment, training or education, and psychological trauma.

In prisons, an ageing prison population means that social care needs are more prevalent among prisoners than in the past, both while serving their sentences and on release. This poses particular challenges to old ways of working. Not only are the over-50s the fastest growing age group in prison, but due to changes introduced from 2015, local authorities have assumed responsibility for meeting the social care needs of people in prisons. In short:

- Money is spent on prisons and high-cost criminal justice and related interventions that could be better spent earlier and upstream.
- Concerted and coordinated local action is needed to provide evidence-based responses that include a strong focus on desistance and prevention.
- This resource seeks to stimulate conversations between local health, social care, criminal justice and other partners aimed at improving health, reducing offending and tackling health inequalities.

Evidence-based interventions and treatments are available for some of the matters under consideration here including substance misuse, mental and physical health problems and aspects of offending and reoffending (see here and here for examples) the evidence is dynamic and evolving. In other areas, such as labour market or housing support, the understanding of 'what works', what is effective and cost effective, is less developed. This highlights the potential, indeed the need, for innovation and robust evaluation, and the importance of sharing learning locally and nationally.

Innovation may involve risk, including the risk of failure, and early intervention may save public money, reduce inequalities and improve lives, but it may struggle to generate rapid cashable savings. Piloting, and robust evaluation, can make the case for interventions and programmes. Securing the backing of local leaders and stakeholders including, where appropriate, the support of local elected leaders, especially PCCs and local councillors, can make an important difference. Understanding where costs and savings of crime and health inequalities accrue, and having a sense of how and where post-intervention savings will lie will be essential.

This document does not set out only to make a case for investment, but also for making better use of existing resources, whether through joint or co-commissioning, pooled budgets, or simply more effective collaboration. Making a case for investment, in what are likely to remain financially constrained times, will require a solid understanding of local need, a clear sense of direction and purpose and an appetite for challenge. Above all, it will require collaboration and partnership – this document aims to set out the case for who and why; the how and what will need to be determined locally.

The case for change

Overview

In recent years there has been a growing awareness that people in contact with the criminal justice system face significant health inequalities, including multiple and complex health and social care needs. Poor individual health and social inequalities are associated and interlinked with an increased propensity to offend. Good health is also seen to contribute to social cohesion[1] and therefore poor health adding to problems of social exclusion may increase the risk of continued offending.[2]

People who commit offences often have multiple and complex health needs, alongside social disadvantages such as persistent unemployment and housing problems which are also recognised as wider determinants of health. Low levels of help-seeking behaviour can be compounded by a range of other obstacles to effective engagement with services, sometimes including inaccessible, poorly designed and/or restrictive services. This can restrict the opportunities for early detection, monitoring and treatment of problems, result in the health needs of this population going unmet and in increased use of relatively expensive emergency services.

Separately and in combination, these social determinants of offending can, over the life course, adversely affect health outcomes, offending behaviour and other outcomes. This may include an individual's vulnerability to crime, difficulty at school, lower educational attainment, limited functional and life skills and distance from the labour market. Furthermore, causality can often flow in both directions and interact in complex ways, so that social exclusion can be both a cause and a consequence of offending, as well as a cause and a consequence of poorer health.

These needs are often also mutually reinforcing with, for example, offending behaviour and substance misuse resulting in housing problems, and homelessness contributing to the initiation of substance misuse and having associations with offending. Therefore, an individual may be affected by a number of social determinants associated with health inequalities and a range of criminogenic needs[3], or risk factors associated with increased offending.

Barriers to progress

People in contact with CJS are often described as being 'underserved' i.e. services are not provided appropriately or accessibly to enable the community to benefit. Therefore, bringing services closer to them may substantially improve uptake, presentation and utilisation, and patient pathways should be designed with this in mind. There are multiple personal and structural barriers to progress:

- **Complex health and social care needs**: high prevalence of co-morbidity and concurrent social problems mean there may be challenges identifying which service should take the lead or services are not sufficiently joined up, so that people find themselves 'bounced' between services or falling through gaps. Alternatively, where individual needs are not sufficiently severe to meet service criteria for secondary or specialised services, primary health care services may not be able to respond appropriately across the range of lower level needs.
- **Poorly designed services and challenging personal and social circumstances**: can lead to difficulties in adhering to rigid appointment systems or attending during regular office hours.

1 Governance for health equity taking forward the equity values and goals of Health 2020 in the WHO European Region Chris Brown Dominic Harrison Harry Burns Erio Ziglio WHO 2014

2 Bowles, R., 2012. Social Exclusion and Offending. In Social Exclusion (pp. 105-125). Physica-Verlag HD.

3 Andrews & Bonta (2010) The Psychology of Criminal Conduct, Anderson publishing. Criminogenic needs tend to be 'dynamic', but also include criminal history as a main determinant of future reoffending.

- **Low levels of help seeking behaviour**: distrust of services, linked to previous negative experiences of contact with statutory services, such as being taken into care, was identified as a barrier in accessing healthcare services in interviews with recently released prisoners.
- **Commissioning arrangements for residents, for example within approved premises:** residents can experience a range of barriers to accessing both primary and secondary health services.[4] Fragmented commissioning between prison and community services can disintegrate the patient pathway.
- **Stigma:** those in contact with the criminal justice system may be the bearers of multiple labels which carry or are perceived to carry stigma: 'offender', 'mentally ill', 'homeless', substance abuser', 'personality disordered'. Such labels can lead to negative attitudes from professionals and act as a barrier to access or engagement with healthcare.
- **Transition to adulthood:** The transition from children's to adult health services can be complex and inconsistent with a detrimental impact on continuity of care. Young people leaving care face particular challenges, being around twenty times more likely to end up in prison than non-care leavers.
- **Fragmented data:** while there is significant data about health and social problems held locally, for offenders in prison and also in the community, none of it is visible to every commissioner or responsible body.

Complex problems, systematic solutions

A place-based planning 'hub', drawing from some of the groups outlined above, is well placed to bring together the four components of a programme of interventions, described below, into a coherent strategy. A plan; do; check and adjust approach might take the form of:

- **Build understanding of the specific health needs of people in contact with the criminal justice system locally:** by developing a place-based planning hub and ensuring that there is a focus of this population in the community in the Joint Strategic Needs Assessment. Engage stakeholders to access relevant health data, and involve people with direct experience of the criminal justice system to inform local strategies and commissioning.
- **Engage with communities:** develop a strategy for engaging with people in contact with CJS who are often underserved by current services. This may be achievable using services and networks that already exist locally.
- **Commission and deliver programmes jointly with partners across the system:** with a focus on preventing and reducing offending and improving access to healthcare; continuity of care between custody and community, informing development of effective health interventions as part of community sentences, and including key partners. This should include developing early intervention and prevention programmes: moving 'upstream' to address shared determinants of poor health and offending, and working with police and NHS England Health and Justice Teams to support early diversion into healthcare.

The fan below, developed by PHE, provides an example of the range of services, commissioners and stakeholders that might need to be involved to address an individual's complex health and social support needs.

4 National Offender Management Service. 2012. A review of healthcare in approved premises: phase 1 report (unpublished report)

- **Monitor and evaluate progress, and adjust activity where necessary:** through understanding the impact at the individual and social level, and the return on investment (including social return on investment), a robust local business case can be developed between stakeholders.

The community dividend

- The community dividend model suggests that by addressing the health needs of those in contact with the criminal justice system there can be positive effects on the wider population.

People in prison or those in their friendship, family and social networks also disproportionately experience wider societal health and social inequalities – they often come from under-served populations, and return to those communities when their immediate involvement in the criminal justice system has ended.

Therefore, meeting the health needs of people in contact with the criminal justice system can help to achieve reductions in crime, reduce offending and improve the individual's health. Developing and delivering health interventions targeted at people in contact with the criminal justice system can also deliver a 'community dividend' providing a beneficial impact on wider health, including health inequalities, and offending behaviour. Therefore delivering effective healthcare to people in prison or in contact with other parts of the criminal justice system is not only the right thing to do but also the wise thing to do.

Examples of the community dividend

There is evidence that children of offenders are three times more likely to have mental health problems or to engage in anti-social behaviour than their peers. Reducing reoffending, and reducing the number of parents that experience incarceration, may reduce their children's future involvement in offending and the criminal justice system.

Fear of crime may increase community anxiety and have adverse health consequences for communities, including being discouraged from engaging in health promoting activities such as cycling and walking. Reducing reoffending – and the fear of offending – locally can play a role in improving public health.

Healthcare delivered in prisons can have a significant impact on improving health and wellbeing both inside and outside the prison, such as the decrease in acute hepatitis B among injecting drug users in the community, which has been attributed, in part, to prison-based vaccination programmes. Identification and treatment of long term conditions will have a benefit by reducing costs of more expensive care if conditions are not managed.

An example of a more direct dividend is supporting people to become more effective parents and/or carers, reducing the likelihood of their children attaining 'looked after' status or going in to local authority care, which has a higher cost to the local authority and is associated with poorer outcomes for the child as they move into adulthood.

Vulnerable offenders and victims of crime

Perpetrators are frequently also victims of crime – success in reducing reoffending lies in addressing their vulnerabilities, not just their offending behaviour. The police and other parts of the criminal justice system, including courts and probation, increasingly think of and respond towards many of the people they come into contact with not only as perpetrators of offences but also as people who are frequently vulnerable in their own right.

Evidence suggests that while the associations are complex and may be driven by common observed and unobserved factors, there is a strong relationship between offending behaviour and being at risk of being a victim of crime.

This shifting of approach towards supporting people who commit offences has been recognised structurally, such as through the increasing provision of Liaison and Diversion services and the move to desistance-based approaches of rehabilitative support that are designed to address criminogenic needs and to reduce future offending behaviour. It has also manifested more broadly in the way that health and social support systems go about providing support to people with histories both of offending and being victimised.

Policy

It is inherent to health inequalities, contact with the CJS and multiple and complex needs that the range of services, activities, stakeholder bodies and organisations with roles to play is of necessity lengthy. Likewise, this activity cuts across multiple policy agendas, whether those agendas are determined in Westminster or more locally.

The following represents a selection of the policy and service areas that are relevant to this agenda. It cannot be, and should not be considered, exhaustive. For example, schools clearly have several roles to play, but education policy has not been included here. Policy has also been taken in a broad sense – not just policy as strategic direction, or even as areas of activity, but as broad themes.

Recent governments have tried to drive systems and sectors to work together to develop a holistic understanding of local need, and to devise responses to match. There are, however, structural and institutional barriers that can be difficult to overcome. This section provides an overview of some of the key policies and mechanisms that relate to understanding needs and developing responses.

Health and wellbeing boards, joint strategic needs assessments and health and wellbeing strategies

Health and wellbeing boards (HWBs) produce joint strategic needs assessments (JSNAs), which in turn inform local Joint health and wellbeing strategies (JHWSs). These present an opportunity – not currently always taken – to ensure that the people in contact with the CJS and others from under-served communities are reflected in local assessment, planning and delivery.

Statutory guidance lists people in contact with CJS in the community as a vulnerable group which should be given particular consideration in assessing and meeting local health needs. PHE has committed to support local authorities to ensure that all JSNAs capture the needs of offenders both in detention and in the community.

The Health and Social Care Act 2013 establishes a minimum membership for health and wellbeing boards. This is a local elected council member, the director of public health for the local authority and representatives of the local Healthwatch organisation, local clinical commissioning group, director for adult social services, and the director for children's services.

To what extent do JSNAs reflect the needs of offenders and others with multiple and complex needs?

During September 2014, health and justice public health specialists based in PHE centres surveyed JSNAs published by 147 local authorities in England. The survey identified any references to the CJS in these documents. Findings indicated 73 (49%) had direct references to health and justice within their published JSNA documents and a further 71 (48%) had indirect references. However, some needs and inequalities relevant to this agenda have, so far, been given less consideration. A review by Homeless Link and St Mungo's looking specifically at the inclusion of the needs of single homeless people in JSNAs and JHWSs found highly variable levels of prominence given.

Police and Crime Commissioners are not statutory members of HWBs, although some PCCs (or their representatives) have been co-opted as members in some areas. As many police service boundaries are not coterminous with local authority boundaries, engaging all HWBs in a police service area is likely to pose a greater challenge for some PCCs than others. The Home Secretary and Secretary of State for Health in November 2016 wrote to all PCCs and HWB chairs highlighting the opportunities presented by partnership approaches, urging them to collaborate closely and to ensure that appropriate representation on HWBs is secured.

Some areas, such as the PCC for the West Midlands, have addressed this by agreeing membership with (most) local authorities with representation on the police side being drawn from both the office of the PCC and the police service itself. Whether through membership of the main HWB, through a relevant working or sub-group, or through an alternative arrangement, local authorities, CCGs and PCCs have a mutual interest in working together to understand local need and to design, commission and evaluate appropriate local responses.

Supporting the joint strategic needs assessment

Directors of Public Health play a key leadership role in developing the local JSNA, and should work closely with criminal justice partners as part of the process. It is also crucial that the analysis considers the distinct needs of specific groups in contact with the criminal justice system, including people with multiple and complex needs, women, young adults (18-24), and those from black, Asian and minority ethnic groups. Key sources will include:

- the National Probation Service and local Community Rehabilitation Company, who can provide valuable information on the health needs of those under probation supervision;
- data from Criminal Justice Liaison and Diversion services, which is reported to NHS Health and Justice commissioning teams; and
- existing Prison and Police Custody Health Needs Assessments conducted by NHS England Health and Justice Teams and police services.

Health and justice public health specialists based in the nine PHE centres can provide support to access the Public Health Outcomes Framework (see below for an overview of the most relevant indicators), plus other Public Health Profile data tools provided by Public Health England. These include detailed annual local substance misuse reports produced by PHE, including prevalence and treatment system performance. Beyond top level data, these are not published but are available to key identified stakeholders via the local PHE centre alcohol and drug manager and local authority joint commissioning managers. PHE produces similar tailored support packs for PCCs, which are similarly not in the public domain, but are sent directly to the offices of each PCC.

Sustainability and Transformation Plans

Sustainability and Transformation Plans (STPs) were introduced in technical guidance released alongside the NHS Five Year Forward View. To deliver them, providers, clinical commissioning groups (CCGs), local authorities, and other health and care services have come together across 44 areas, known as footprints, in England. These multi-year plans must be place-based and designed around the needs of local populations. Among the ambitions of STPs is to drive the integration of health and social care, and improve public and population health to reduce healthcare demand and tackle health inequalities.

STPs provide the NHS with an opportunity to work closely with local government and other local partners to build on existing local efforts and, crucially, strengthen and implement preventative interventions that will close the local health and wellbeing gap, such as:

- providing targeted advice and integrated care to tackle excessive alcohol consumption and smoking;
- creating healthy environments in health and care settings to improve diets and keep people in work, and support action to reverse trends in childhood and adult obesity; and
- intervening earlier and managing conditions better to keep people healthier for longer and reduce their care needs.

Troubled families

The Troubled Families programme has involved providing tailored support to families who meet particular criteria. When announced in 2010, the programme was described as an integrated approach to early intervention, with the ambition that the programme would

> Help turn around the lives of families with multiple problems, improving outcomes and reducing costs to welfare and public services. The campaign will be underpinned by local Community Budgets focused on family intervention – enabling a more flexible and integrated approach to delivering the help these families need.

The evaluation of the first wave of the programme was published in November 2016 and presented a mixed picture with regard to the impact of the programme. The evaluators found that the programme had raised the profile of family intervention nationally, and had transformed the way services were being developed for families in many areas, including stimulating multi-agency partnership working. However, the evidence around the achievement of key programme outcomes was less clear. The expanded programme will continue to roll out, learning from the evaluation.

Police and Crime Commissioners – the second generation

The first generation of Police and Crime Commissioners (PCCs) were elected in 2012. They and their offices replaced Police Authorities and provide accountable and visible local leadership across policing and crime prevention.

The Association of Police and Crime Commissioners (APCC) highlights that under the terms of the Police Reform and Social Responsibility Act 2011, PCCs must:

- secure an efficient and effective police for their area;
- appoint the Chief Constable, hold them to account for running the force, and if necessary dismiss them;
- set the police and crime objectives for their area through a police and crime plan;
- set the force budget and determine the precept;
- contribute to the national and international policing capabilities set out by the Home Secretary; and
- bring together community safety and criminal justice partners, to make sure local priorities are joined up.

PCCs also have a significant commissioning remit, aspects of which have been explored in Revolving Doors Agency's First Generation project, funded by Barrow Cadbury Trust. With the second elections having taken place in May 2016, Revolving Doors Agency's work is now continuing as the Second Generation. PCCs can, depending on local circumstances, play a bigger role in fire and rescue services, and there are plans to further broaden the role to potentially include other aspects of the CJS.

Integrated offender management

Integrated offender management (IOM) is a locally led cross-agency response to the crime and reoffending threats faced by communities. It works through managing the most persistent and problematic offenders identified jointly by partner agencies working together. IOM helps to improve the quality of life in communities by reducing the negative impact of crime and reoffending, reducing the number of people who become victims

of crime, and helping to improve public confidence in the criminal justice system.

Mental health policy

The Mental Health Crisis Care Concordat aims to improve responses to people in mental health crisis, many of whom come into contact with the police. It brings key partners together to agree shared action plans to improve crisis care pathways. The aims of the action plans are to support reductions in the inappropriate use of police custody suites as places of safety, ensure they are only used in exceptional circumstances, and that health-based and alternative places of safety should become more readily available.

£15m of Department of Health money has been made available to support forty four local Concordat Group partnerships to increase local provision of places of safety. The types of projects funded include new section 136 suites, crisis cafés, triage vehicles and places of safety for children and young people.

The Five Year Forward View for Mental Health contains a cross-government commitment to improve pathways for those affected by mental ill health:

> "The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed."

The most recent National Police Chiefs Council data show that Police stations in England and Wales were used as a place of safety under section 136 of the Mental Health Act on 2,100 occasions in 2015/16 - a 54% reduction from 2014/15.

This has been accompanied by an implementation plan, which provides detail of how the objectives of the Forward View will be achieved, including around health and justice. This includes the continued roll-out of Liaison and Diversion, aiming for full coverage by 2020-21, and the use of data and other system levers.

PHE collates and publishes data to support an intelligence driven approach to mental health crisis care planning, in addition to data around common mental health problems and data around severe mental illness and community mental health profiles, at CCG rather than local authority geographies.

The Police and Crime Bill currently progressing through parliament contains provisions to prohibit people aged under 18 being held in police custody under the Mental Health Act, to ensure that adults are detained in police custody only under exceptional circumstances and reduce the maximum permitted detention time from 72 hours to 24 hours.

Liaison and Diversion

Liaison and Diversion (L&D) services exist to identify people with mental health problems, learning disabilities and substance misuse problems at the earliest point after initial contact with the police and criminal justice system. The purpose of L&D is to ensure that people receive support and treatment through the criminal justice pathway in a way that addresses any underlying and possibly contributory health factors – in essence, better justice and better health.

In some areas L&D has a lengthy history, although the national focus, including a standardised operating motel, has been driven in large part by the recommendations of the 2009 Bradley Report. Revolving Doors, as part of the Offender Health Collaborative, worked with NHS England to develop the national operating model for L&D, one of a suite of resources produced by NHS England, which commissions L&D services.

Local leaders, working with NHS England commissioners can maximise the opportunities presented by L&D. Expert opinion suggests that where community services are unavailable, or where people

requiring diversion are not prioritised, use of custody can result. This again emphasises the importance of local leaders across multiple systems working together to maximise access and achieve the best and broadest value for their investment.

L&D is subject to a large scale, long-term evaluation.

Substance misuse policy

Key related government policies and strategies, such as the 2010 Drug Strategy and the Transforming Rehabilitation reforms, emphasise the association between drug misuse and offending, and the role of substance misuse treatment in reducing offending and reducing its impact on families and communities. The Drug Strategy also emphasises the necessity of a holistic response, recognising the importance of supporting people to secure rewarding employment, stable accommodation and positive social networks – or jobs, homes and friends.

The 2012 Alcohol Strategy emphasises the associations between alcohol misuse, health risks and violence, as well as containing a commitment to piloting an alcohol abstinence monitoring requirement (AAMR) as a sentencing option. The AAMR has since been piloted and evaluated in London and is being evaluated elsewhere.

Coexisting substance misuse and mental ill health

PHE and partners will also be publishing revised guidance on coexisting substance misuse and mental ill health in 2017. Given the high prevalence of comorbidity, local leaders should ensure that assessment and intervention pathways should be as integrated and streamlined as possible and, where practicable, based on the principle of 'no wrong door' – that someone presenting with a mental health need, a substance misuse need or a combination, should be able to receive a service or to be seamlessly referred no matter which service they access at first instance.

Public Health England: strategic plan for next the four years – better outcomes for 2020

Health and justice forms part of Public Health England's (PHE's) strategic plan. In their work with local authorities, PHE commits:

> "To work with local government, police and crime commissioners, NHS England and clinical commissioning groups to raise awareness about how they can improve the health of offenders as well as help reduce reoffending behaviour."

Employment support and labour market programmes

Some local areas already include employment support in their JSNA and JHWS and, among areas where devolution deals are in place; new labour market programmes with a focus on those with health conditions are being introduced. From 2017, a new Work and Health Programme will be established with the objective of transforming employment support for those furthest from the labour market — those with health conditions and disabilities and the very long term unemployed. In areas with devolution deals, this will include co-commissioning and/or co-design between the Department for Work and Pensions and the relevant combined authority, and should present an opportunity to build on the learning of innovative local schemes such as Manchester, Salford and Trafford's Working Well programme.

Welfare reform

Universal Credit (UC) will continue to roll out. The conditionality regime for UC is analogous to the legacy benefits Jobseeker's Allowance (JSA) and Employment and Support Allowance (ESA). However, payment arrangements are different, centred around a single monthly payment to one member of a household. Alternative payment arrangements (APAs) may be applied where a claimant is likely to face significant problems managing their money, or when they have fallen into arrears of rent. Budgeting support should also be available, as should a local network of Universal Support. These are services which aim to smooth the transition to UC, and are offered to people with histories of mental ill health, substance misuse, gambling, offending and homelessness.

Understanding need

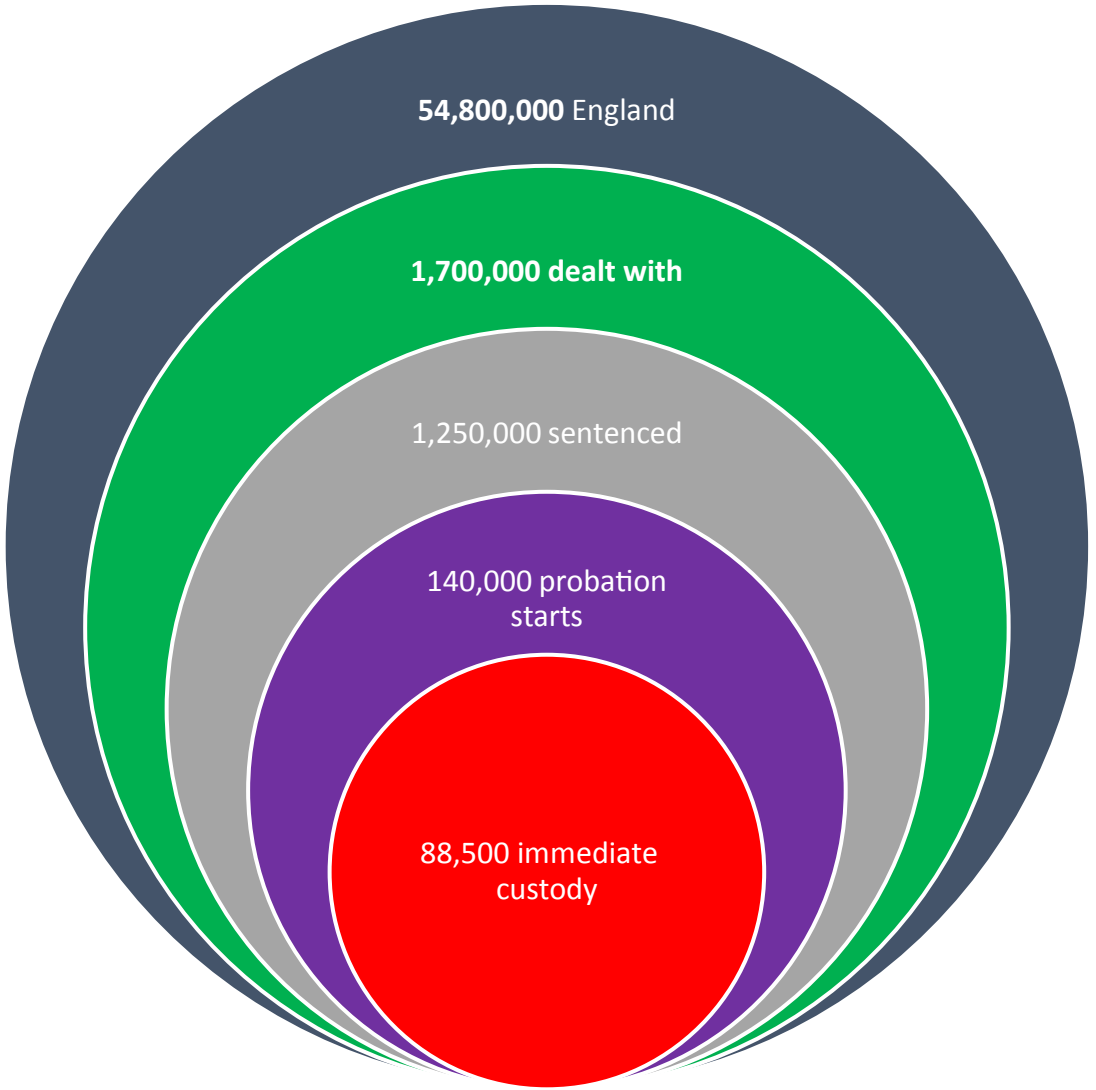
Defining the population

The population in contact with the criminal justice system is far larger than the prison population. All people serving a custodial sentence come from communities, and almost all will return to their community, or another community, at the end of their sentence. At any one time, the proportion of offenders supervised by probation services outnumbers those serving a custodial sentence by around 3 to 1.

In comparison to the 1.7 million people dealt with formally by the police in 2014-15 and the almost roughly 140,000 people referred to probation in the same year, prison receptions amounted to roughly 90,000 people in the 12 months ending December 2015.

In addition to dealing with people suspected of an offence, the police also interact with many victims of crime and with many other people informally. Police powers under the Mental Health Act – which will not necessarily indicate an offence having taken place - were used just under 25,000 times in 2016-16.

The number of people convicted of an offence who receive an immediate custodial sentence is gradually falling, although

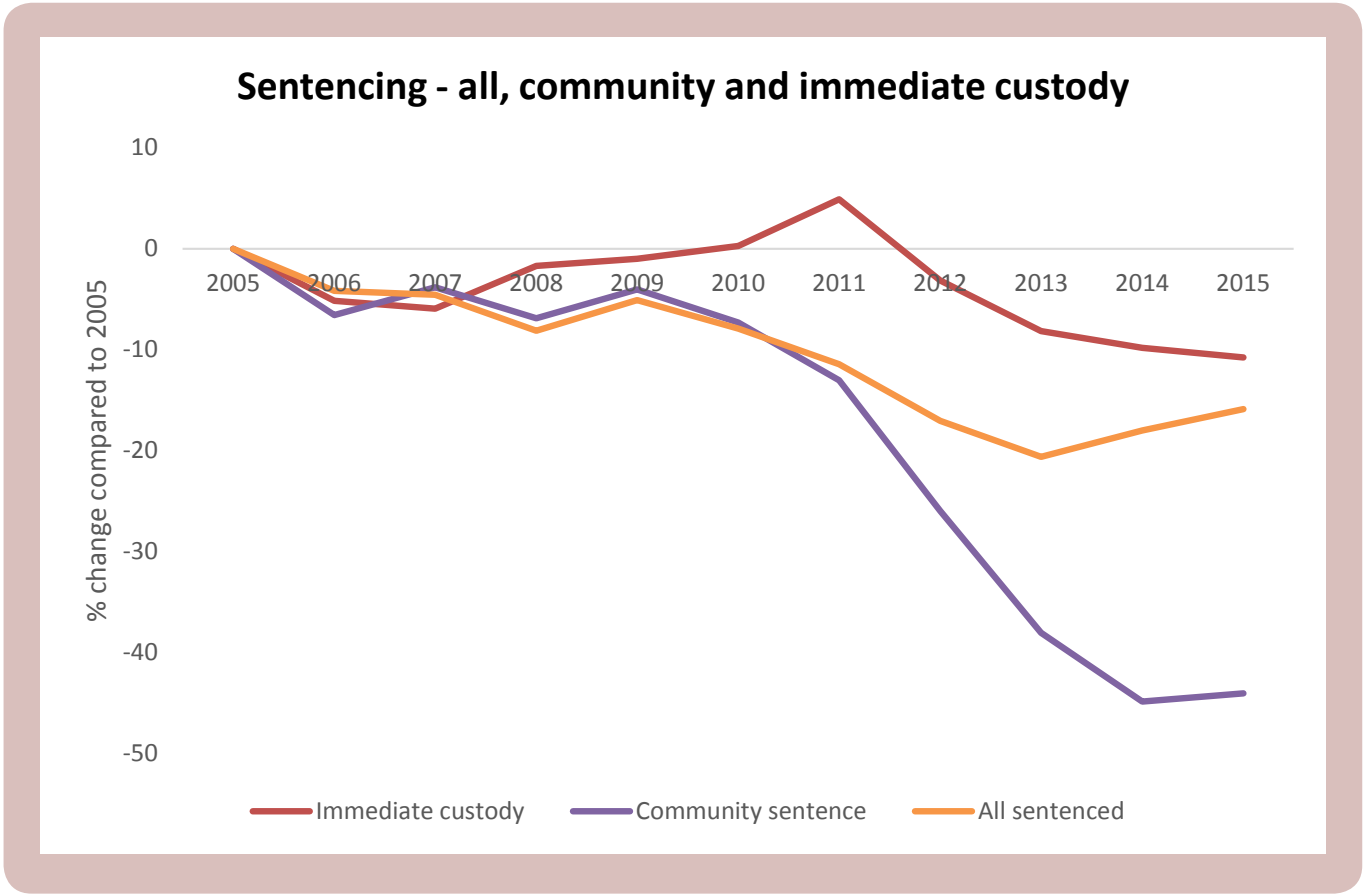


the prison population is not falling to the same extent due to the average length of a custodial sentence increasing. The use of community sentences, which can include requirements such as mental health treatment, alcohol misuse treatment and drug misuse treatment, is also declining - substantially and rapidly.

Of the approximate 88,500 people sentenced to immediate custody in the 12 months to September 2015, roughly half will have been released from prison in under 12 months. Despite this, the average prison length sentence has risen steadily from just under 13 months to over 16 months between 2005 and 2016. This is primarily due to a significant increase in the number of people receiving sentences of 10 years or longer.

This increase is attributable to several factors, including the offence make-up of the prison population changing towards offences that carry longer sentences, including violence against the person, sexual offences, and drug offences. The increased use of longer sentences means that even while the number sentenced to immediate custody has been relatively stable, the prison population has tended to increase.

However, the fall in community sentences has been marked, despite there being evidence that community sentences can be an effective means of reducing offending, can be less



disruptive to the individual and can offer opportunities to engage the offender with medical treatment and social support.

While it is tempting to think solely in terms of upstream and down-stream interventions, it is important to note that sentencer behaviour and decision making is relevant to this agenda too, and may be influenced by an understanding or misunderstanding of local provision relating to elements such as drug, alcohol or mental health treatment requirements.

While prison will remain an appropriate disposal in some cases, sentencers need effective community-based options to end an over-reliance on costly short prison sentences. Ensuring that local judges and magistrates are aware of the availability of services

that can contribute to community sentence requirements is vital if sentencers are going to retain confidence in considering a community sentence as an alternative option.

Multiple and complex needs

Many people in contact with the criminal justice system will experience multiple and complex needs – coexisting health and social problems, such as substance misuse, mental ill health and housing problems alongside offending behaviour. These problems may be compounded by others, such as poor physical health and social factors such as unemployment, persistent poverty and debt.

A recent report found that the 'average' local authority has around 1,470 people in contact over the course of a year with two or more out of substance misuse services, homelessness services and/or the criminal justice system. Estimated costs per person per year range from around £10,000 to slightly over £20,000 per year, much of it avoidable if better service responses could be provided.

People in prison

Compared to the broader population, people in prisons experience a range of social, physical and mental health problems, impairments and barriers to equitable participation in society. The prevalence of needs among offenders in the community may be similar in character but not necessarily extent; as there is limited comprehensive information about the health needs of offenders in the community, the prison population has been used as a proxy.

These health and social needs can include:

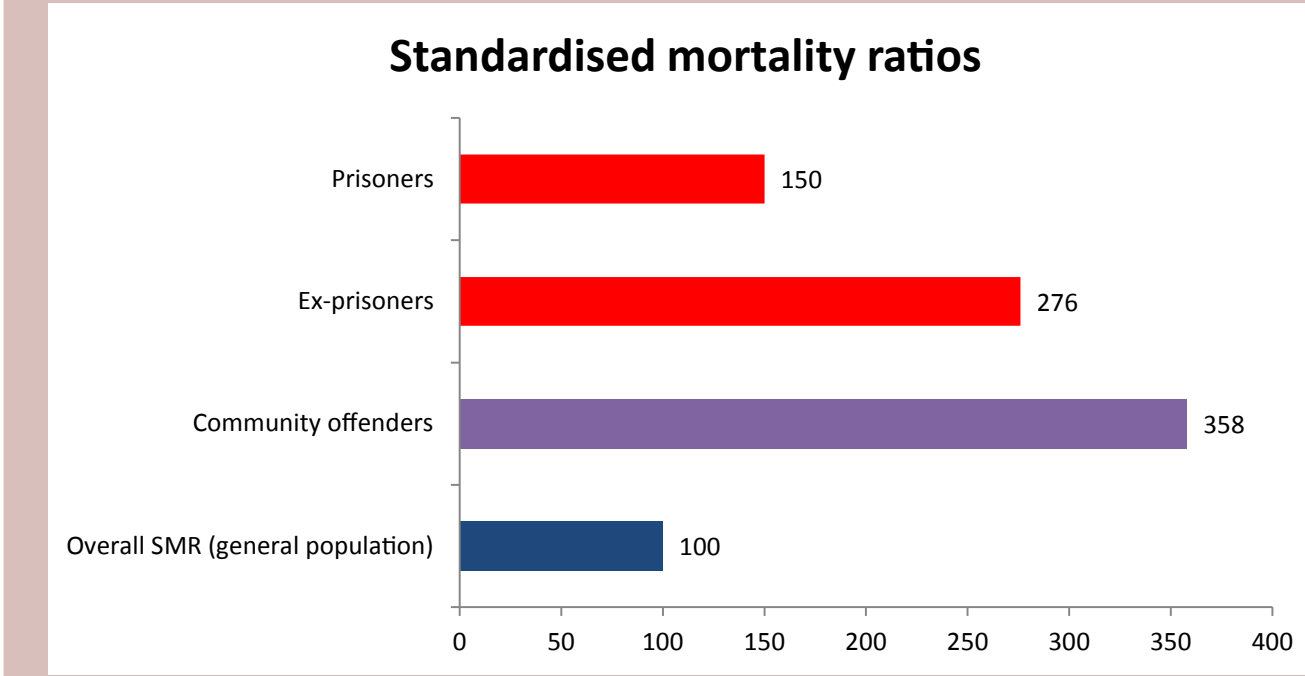
- higher prevalence of infectious diseases, and poorer vaccine coverage;
- higher prevalence of long-term conditions;
- higher prevalence and rates of substance misuse, including tobacco consumption;
- higher prevalence of mental ill health;
- higher levels of learning disabilities and lower educational attainment;
- a disproportionate number having been in care as a child; and
- high rates of pre-sentence homelessness, insecure housing and worklessness.

Each of these needs will require a response both while the person is in prison, and also upon release. PHE and partners have produced a range of resources to help prison management to assess the health needs of their prisons – the Health and Justice Health Needs Assessment Templates. There are separate templates for prisons, prescribed places of detention and for police custody.

Although many different services and providers may capture data relating to health and social problems, the data are often fragmented, not visible in their entirety to any one individual or service and, in some cases, based on surveys, assessments or studies that are limited in geographical scope. To develop a more nuanced understanding of local need, stakeholders could also consider how data can be usefully segmented – such as by age, gender, sexual orientation and/or ethnicity.

Mortality rates

While prisoners have a mortality rate about 50% higher than the population, released prisoners and offenders in the community, such as probationers, have over two to over three times the population mortality rate. As these mortality ratios relate to research conducted in the late 1990s, a degree of caution should be used in interpreting these figures. However, taken over two years, the findings suggest that for both offenders serving probation orders in the community and those who have been released from prison, there is a substantially higher mortality rate. The study found violent death (suicide, accidental death, homicide and other violent death) among community offenders to be an even greater problem than among people in prison. Both offender groups were similarly vulnerable to suicide/self-inflicted death; however, the risks of accidental death and homicide were greater for community offenders. Drugs and alcohol played a bigger part in the death of community offenders. As with the research below, this study found that the weeks immediately after release from prison were where the risk of death was highest.



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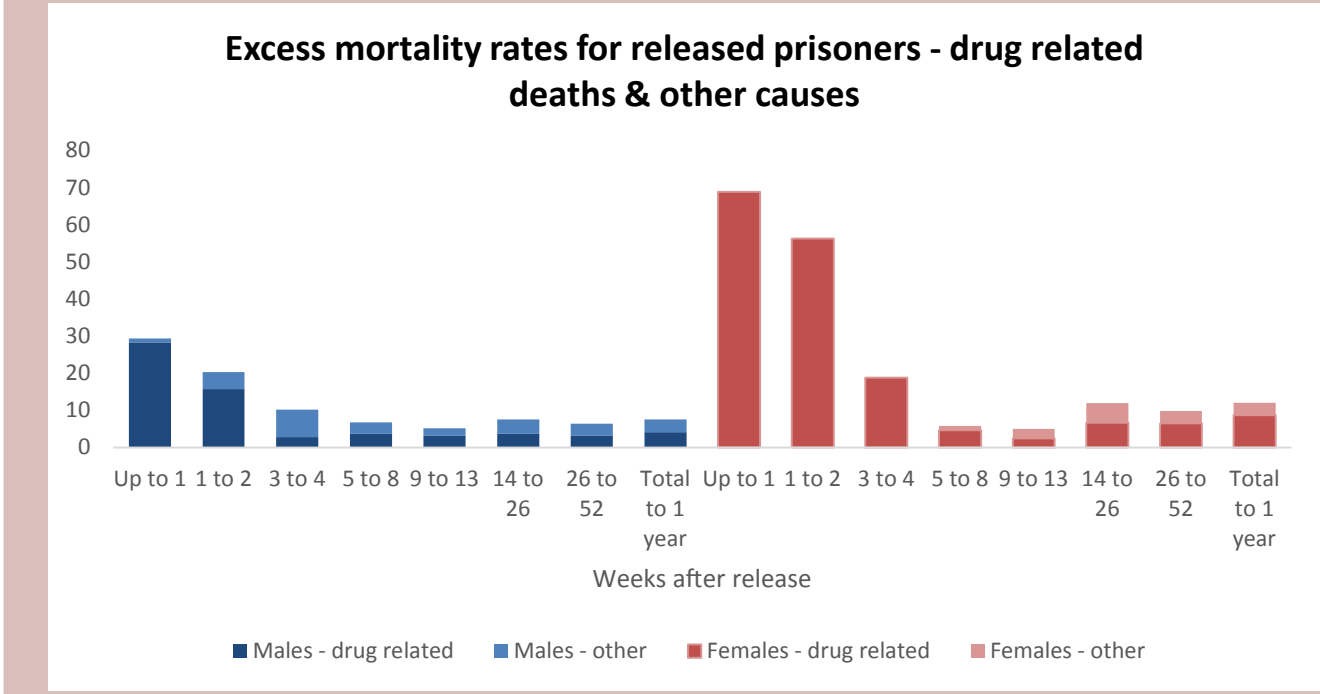
5 http://www.ohrn.nhs.uk/resource/Policy/Ratesdeath.pdf

Drug related deaths

The likelihood of a released prisoner dying due to drug misuse is greatly increased immediately after release, before tapering. As access to drug treatment appears to have a protective effect, ensuring rapid and effective pick-up between prison and community drug treatment may reduce the likelihood of drug related death. PHE has published guidance on the provision of naloxone, which can reduce the risk of drug related death.

Statistics on the pick-up rate between prison and community drug treatment are now published annually by PHE. There is significant variation between the areas with the highest and lowest 3-week pick-up rates between prison and community drug treatment, with the North East having the highest rate of 44.4% and London the lowest of 20.1%. These regional rates mask similar disparities within as well as between regions, raising the possibility of relatively 'quick wins' based on supporting existing services to work more closely together. Expert opinion suggests that the pick-up rate for drug treatment is likely to be higher than for other needs, including mental ill health, and that coordinated efforts to improve pick-up rates for all services, including General Practitioners, can help to ensure that the needs of this underserved population are more effectively met.



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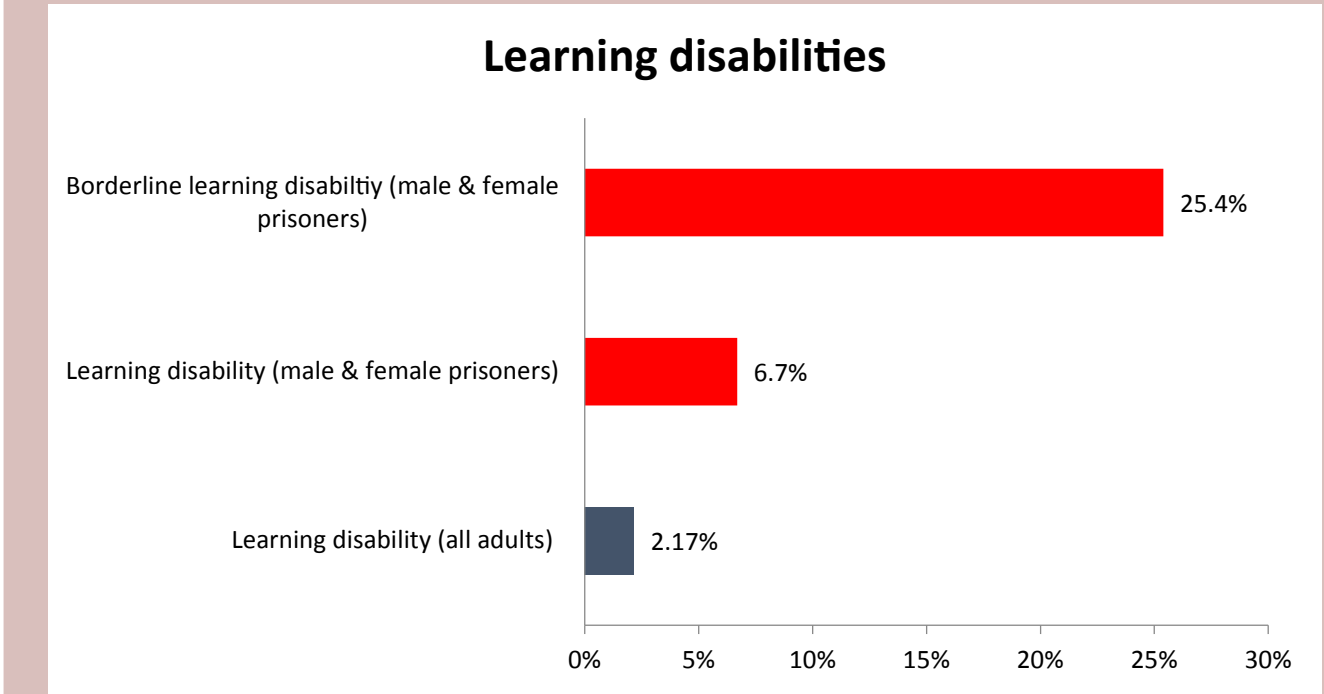
6 Farrell, M and Marsden, J. (2007) Acute risk of drug related death among newly released prisoners in England and Wales. Society for Study of Addiction 103(2): 251-255.

Learning disabilities

Up to one quarter of the prison population are understood to have difficulties in communicating and/ or processing new or complex information, while not meeting the strict diagnostic criteria for a learning disability. Consequently, many may not be eligible for support from community learning disability services following release.

People with a learning disability are at increased risk of a range of physical health conditions as well as some mental health conditions, including schizophrenia. However, difficulties in understanding and communicating health needs, a lack of support to access services, discriminatory attitudes among health care staff and failure to make 'reasonable adjustments' can create significant barriers in utilising mainstream healthcare services. A guide produced by the Royal Colleges of General Practitioners and Psychiatrists with the Learning Disabilities Observatory (now part of PHE) explores the evidence and the surrounding issues more thoroughly.



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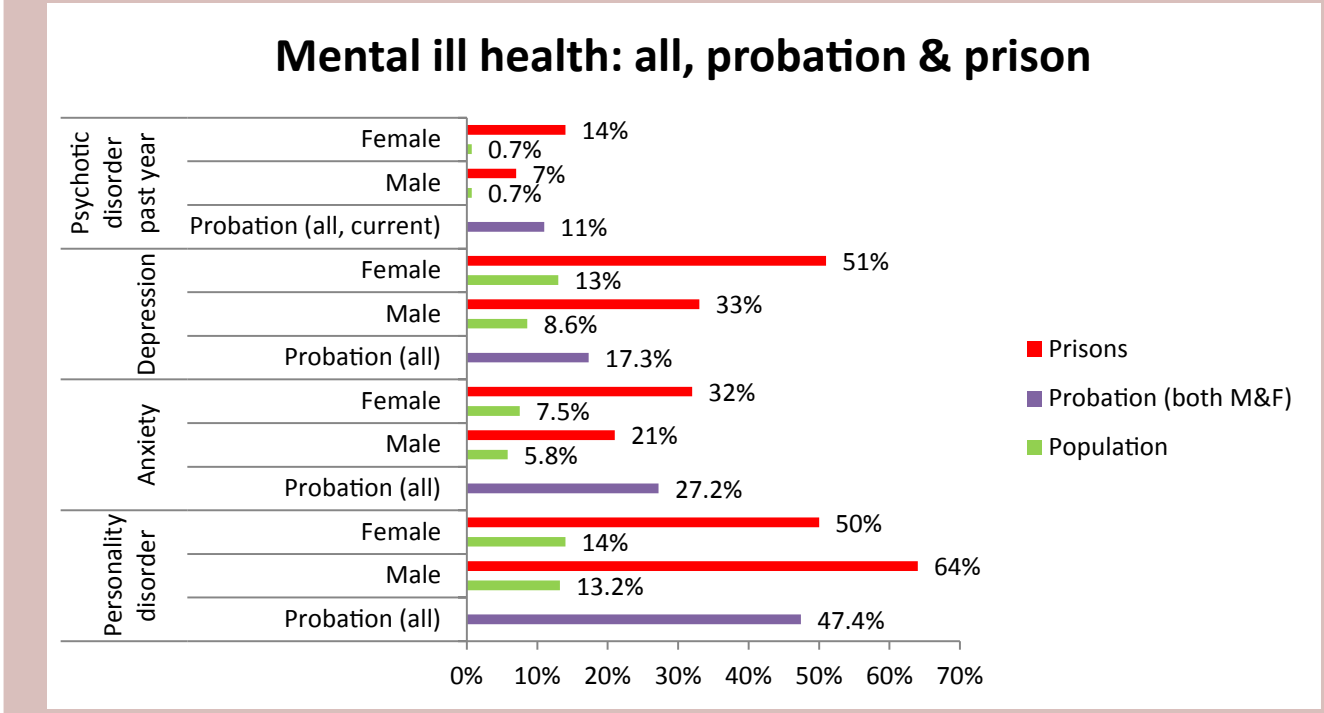
7 https://www.improvinghealthandlives.org.uk/securefiles/160629_1601//People%20with%20learning%20disabilities%20in%20England%202013.pdf & http://www.prisonreformtrust.org.uk/uploads/documents/noknl.pdf

Mental ill health

One in four British adults experiences at least one diagnosable mental health problem in any one year. Some estimates put the amount of police time spent dealing with those with mental ill health issues at between 20% and 40%. This represents a significant financial cost in police time and custody costs. Not all of these incidents will relate to offences and offending; many will involve police participation in a mental health crisis or emergency where there has been no offence.

Rates of prevalence of mental ill health can also be observed that differ according to gender. Prevalence of mental ill health and/ or personality disorder also tends to be higher among the probation caseload, or offenders in the community, than among the general population. More recent, but smaller, studies suggest that mental ill health in prisons continues to be both more prevalent and more severe.



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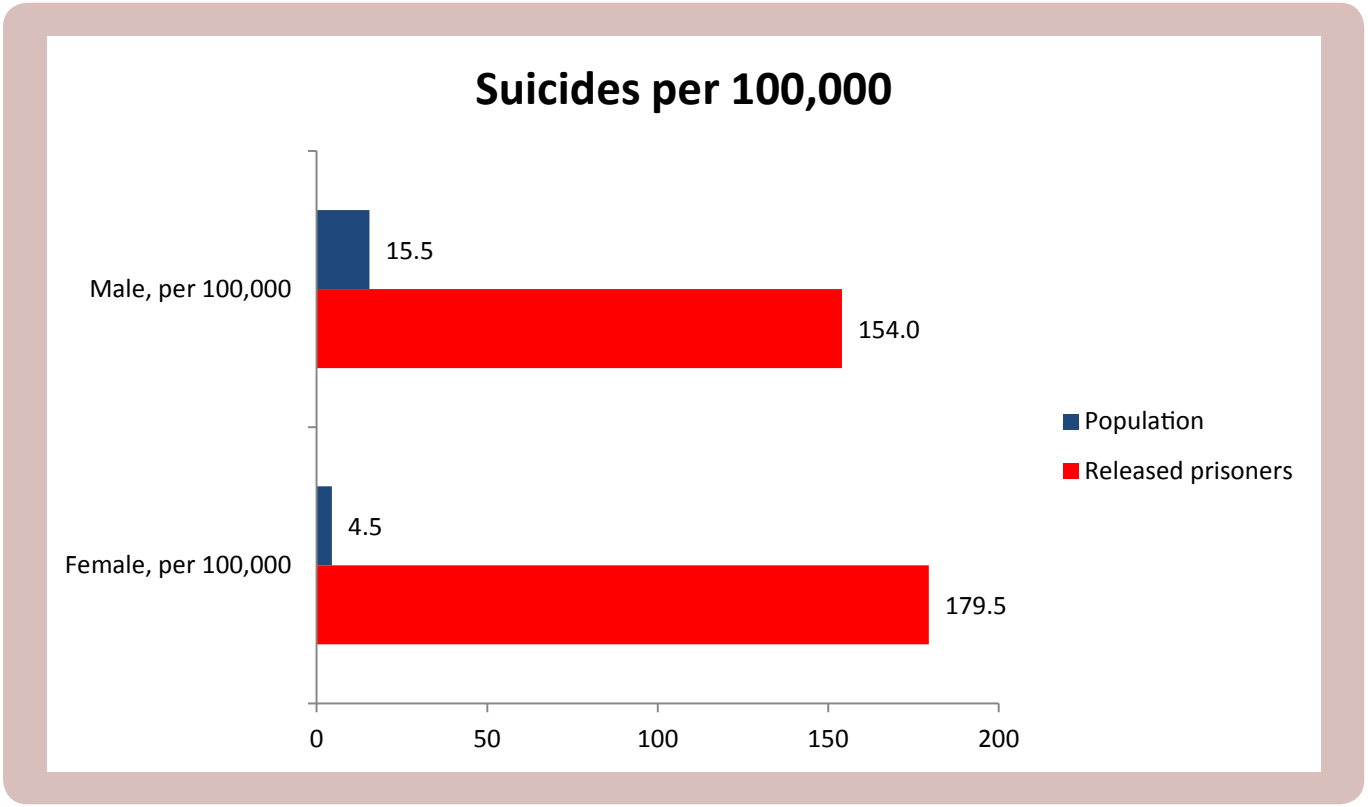
8 http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-prisoners/psychiatric-morbidity-among-prisoners--summary-report/psychiatric-morbidity---among-prisoners--summary-report.pdf , http://content.digital.nhs.uk/catalogue/PUB21748 & http://www.tandfonline.com/doi/full/10.1080/14789949.2012.704640

Risk of suicide

People in contact with the criminal justice system are recognised as a priority group within the current cross-government suicide prevention strategy, and have substantially more risk factors for suicide, including increased prevalence of mental illness, substance misuse and socioeconomic deprivation.

Additionally, the most recent Adult Psychiatric Morbidity Survey revealed other groups where particularly high levels of personality disorder and mental ill health appear to be found. This includes Employment and Support Allowance (ESA) claimants, who have far higher prevalence of personality disorder and extremely high prevalence of suicidal thoughts and suicide attempts.

The risk of suicide is highest in the 28 days following release. A study in 2006 found that "recently released prisoners are at a much greater risk of suicide than the general population, especially in the first few weeks after release. The risk of suicide in recently released prisoners is approaching that seen in discharged psychiatric patients. A shared responsibility lies with the prison, probation, health, and social services to develop more collaborative practices in providing services for this high-risk group."[9]



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PHE publishes suicide prevention profile data which collates and presents a range of publically available data on suicide, associated prevalence, risk factors, and service contact among groups at increased risk.

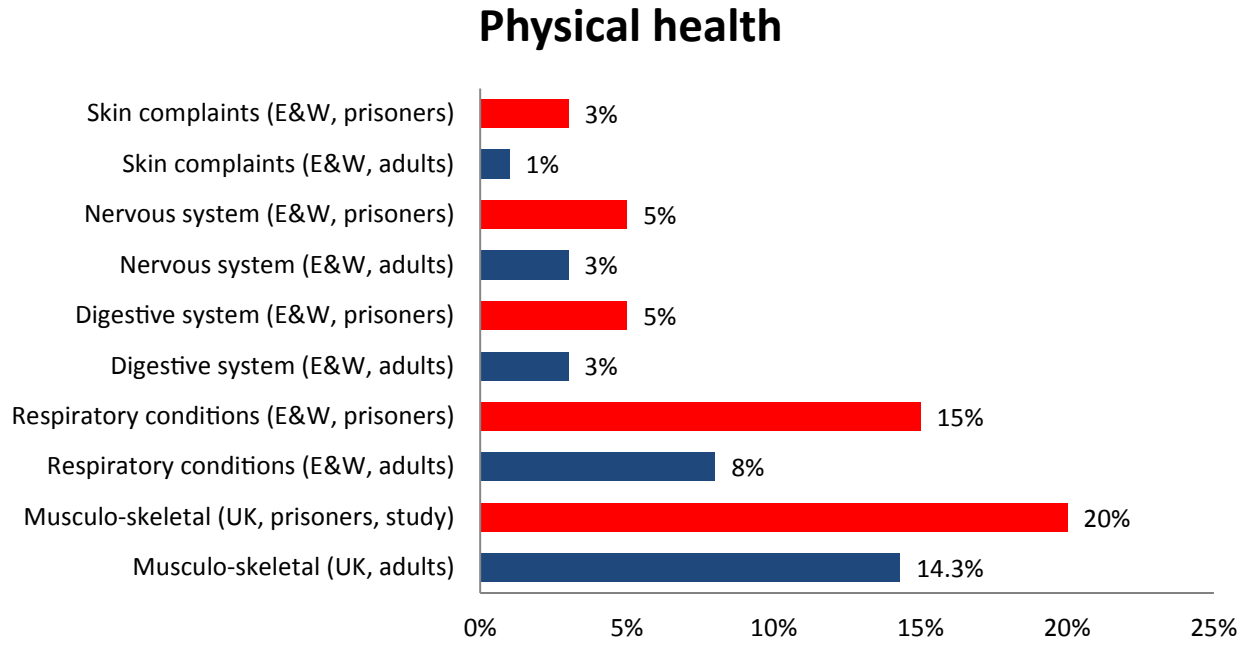
9 Pratt, D., Piper, M., Appleby, L., Webb, R. and Shaw, J., 2006. Suicide in recently released prisoners: a population-based cohort study. The Lancet, 368(9530), pp.119-123.

10 **http://www.sciencedirect.com/science/article/pii/S0140673606690028**
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicideinenglandandwales

Physical health and blood-borne viruses

In addition to higher prevalence and severity of mental ill health, the physical health of the prison population tends to be poorer than that of their counterparts across a broad range of conditions. This reflects the high incidence of the social determinants of poorer health among the prison population, including deprivation, involvement in the care system, and being affected by violence and/or abuse in the home.

In addition to the prison population, there is evidence that detainees held in police custody also experience relatively poor health. A study of over 200 detainees from 2007 identified 'a very large and complex, mixed disease and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis, deep vein thrombosis and pulmonary embolism, hypertension, gastrointestinal disorder, hepatitis and musculo-skeletal issues (MSK), were all present with >5% representation'.



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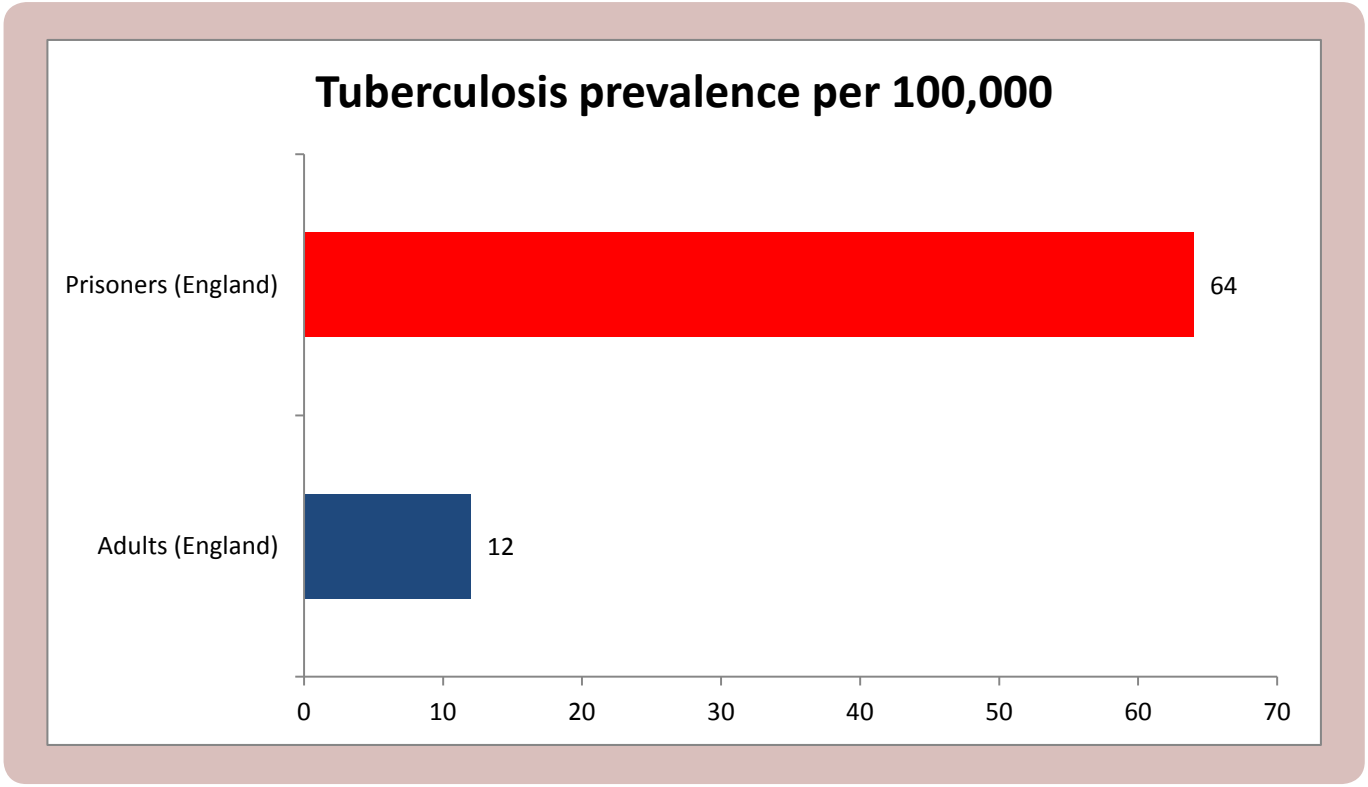
11 http://insight.oxfordshire.gov.uk/cms/system/files/documents/Health%20care%20in%20prisons.pdf
http://www.inflammation-repair.manchester.ac.uk/musculoskeletal/aboutus/publications/heavyburden.pdf
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4616963/
https://www.escholar.manchester.ac.uk/api/datastream?publicationPid=uk-ac-man-scw:123774&datastreamId=FULL-TEXT.PDF

Tuberculosis cases per 100,000 of population have generally been far higher in England than in other parts of the UK, and far higher in London than in most of the rest of England. While many authorities have a tuberculosis rate of between 0 and 4.9 per 100,000, the London boroughs of Brent and Newham have rates of around 83 and 100 respectively.



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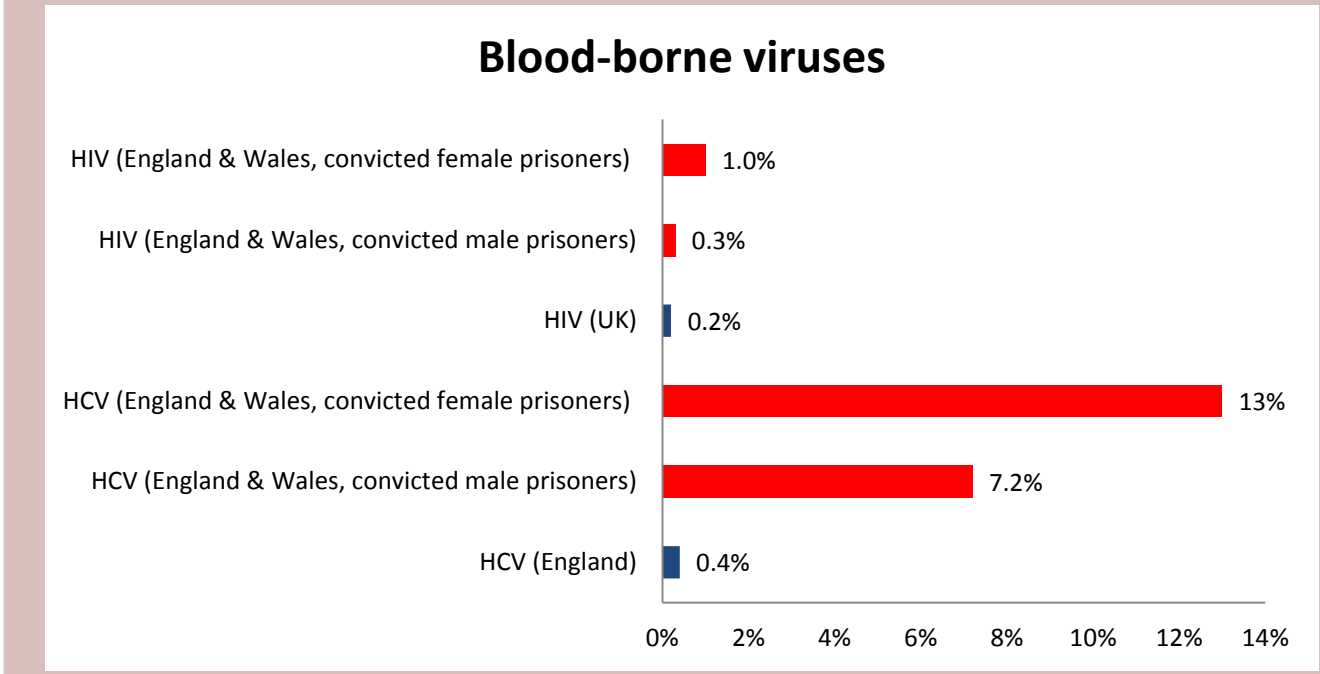
12 https://www.gov.uk/government/publications/prison-health-health-and-justice-annual-report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492431/TB_Annual_Report_v2.6_07012016.pdf

The prevalence of blood-borne viruses, such as HIV and hepatitis C is substantially higher among the prison population, with greater prevalence seen among female prisoners.



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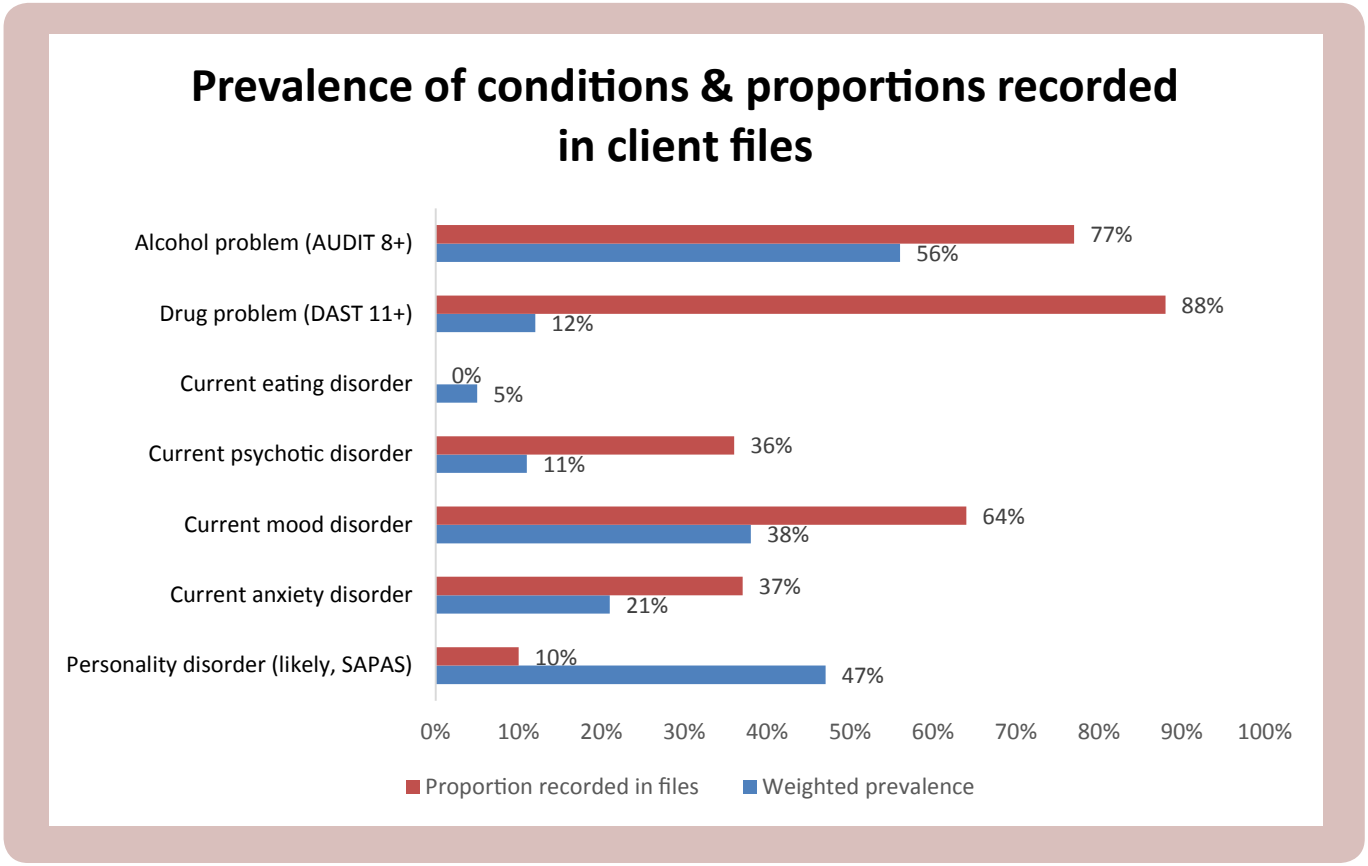
13 http://www.nat.org.uk/Media%20Library/Files/PDF%20documents/prisonsreport.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477702/HIV_in_the_UK_2015_report.pdf
http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.489.6159&rep=rep1&type=pdf

The prevalence of health problems within this group and the difficulties inherent to seeking to support an underserved population emphasise the importance of identifying and recording health and social problems accurately. The chart below is drawn from a study conducted on behalf of a (former) probation trust, and illustrates that levels of need recorded in client files did not reflect the level of need among the trust's clients. For example, while 11% of the trust's clients met the diagnostic criteria for a current psychotic disorder, only one third of that level of need was reflected in client files. Planning the effective provision of services proportionate to need will not be aided by under and misidentification of need.



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14 http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.489.6159&rep=rep1&type=pdf

Substance misuse

Substance use among sentenced prisoners and those on remand is substantially higher than among the wider population. A substantial proportion of new entrants to community substance misuse treatment arrive via a criminal justice system route; in 2015-16 the criminal justice system was the second most common referral source for opiate clients, accounting for 27% of referrals. By contrast, only 8% of clients starting treatment for alcohol arrived via from the criminal justice system.

In addition to the association between drug misuse and acquisitive crime, and alcohol misuse and violent crime, there are multiple health harms associated with each.

	Cost (£m)	% of total cost
Drug-related crime		
Fraud	£4,866	32%
Burglary	£4,070	26%
Robbery	£2,647	16%
Shoplifting	£1,1917	12%
Drug arrests	£535	3%
Health costs		
Inpatient care	£198	1.2%
Inpatient mental health	£88	0.6%
A&E	£81	0.5%
Community mental health	£61	0.4%
GP visits	£32	0.2%
Neonatal effects	£3	0.1%
Infectious diseases	£35	0.1%
Drug-related deaths	£923	6%
Social care	£69	0.4%
Total	**£15,337**	**99%**

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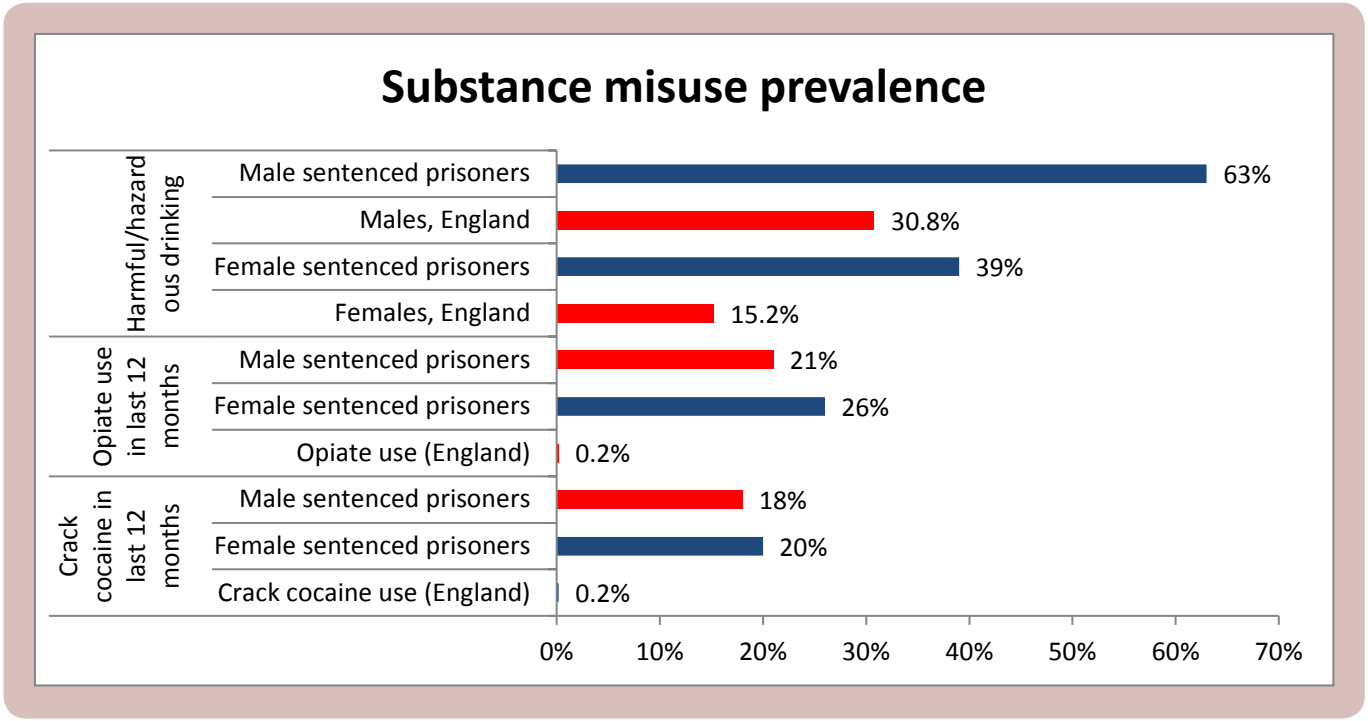
15 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/562775/Health_and_justice_report_2014.PDF

In addition to increased risk of BBVs and other chronic conditions associated with drug misuse, the number of drug related admissions to hospital in 2014-15 was the highest for a decade, while the number of drug related deaths was the highest ever. Liver disease is now the only major cause of death that is increasing year on year, with over twice as many people dying of liver disease now compared to 1991. While multiple factors contribute to this increase, alcohol consumption, and hepatitis B and C, are the primary reason for the increase.

PHE publishes regular prevalence estimates that provide information about drug misuse at local authority level, in addition to limited local treatment data published against the Public Health Outcomes Framework and also via the National Drug Treatment Monitoring System (NDTMS). PHE also publishes local data on concurrent use of mental health and substance misuse services. While this provides a useful indicator of local take-up of services, it will necessarily not indicate any level of local unmet need.

In addition to the high prevalence of substance misuse among the prison population, there are associations between socioeconomic deprivation as measured by Indices of Multiple Deprivation and the prevalence of problem drug misuse and drug related deaths.



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The picture is different for alcohol misuse, with consumption generally tending to increase with income although the effect of the 'alcohol harm paradox' is that those on lower incomes experience more health harms. Potential explanations for this include that high alcohol consumption may be one of several health challenging behaviours[17] and, that while those of lower socioeconomic status may be less likely to exceed recommended limits, they may be more likely to breach more extreme thresholds.[18] PHE publishes the Local Alcohol Profiles for England (LAPE) that provides local data alongside national comparisons.

16 Meltzer, H., Farrell, M., Singleton, N. and Office for National Statistics, London (United Kingdom);, 1999. Substance misuse among prisoners in England and Wales Further analysis of data from the ONS survey of psychiatric morbidity among prisoners in England and Wales carried out in 1997 on behalf of the Department of Health & **http://content.digital.nhs.uk/catalogue/PUB21748**

17 Bellis, M.A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I. and Jones, L., 2016. The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. BMC public health, 16(1), p.1.

18 Lewer, D., Meier, P., Beard, E., Boniface, S. and Kaner, E., 2016. Unravelling the alcohol harm paradox: a population-based study of social gradients across very heavy drinking thresholds. BMC Public Health, 16(1), p.1.

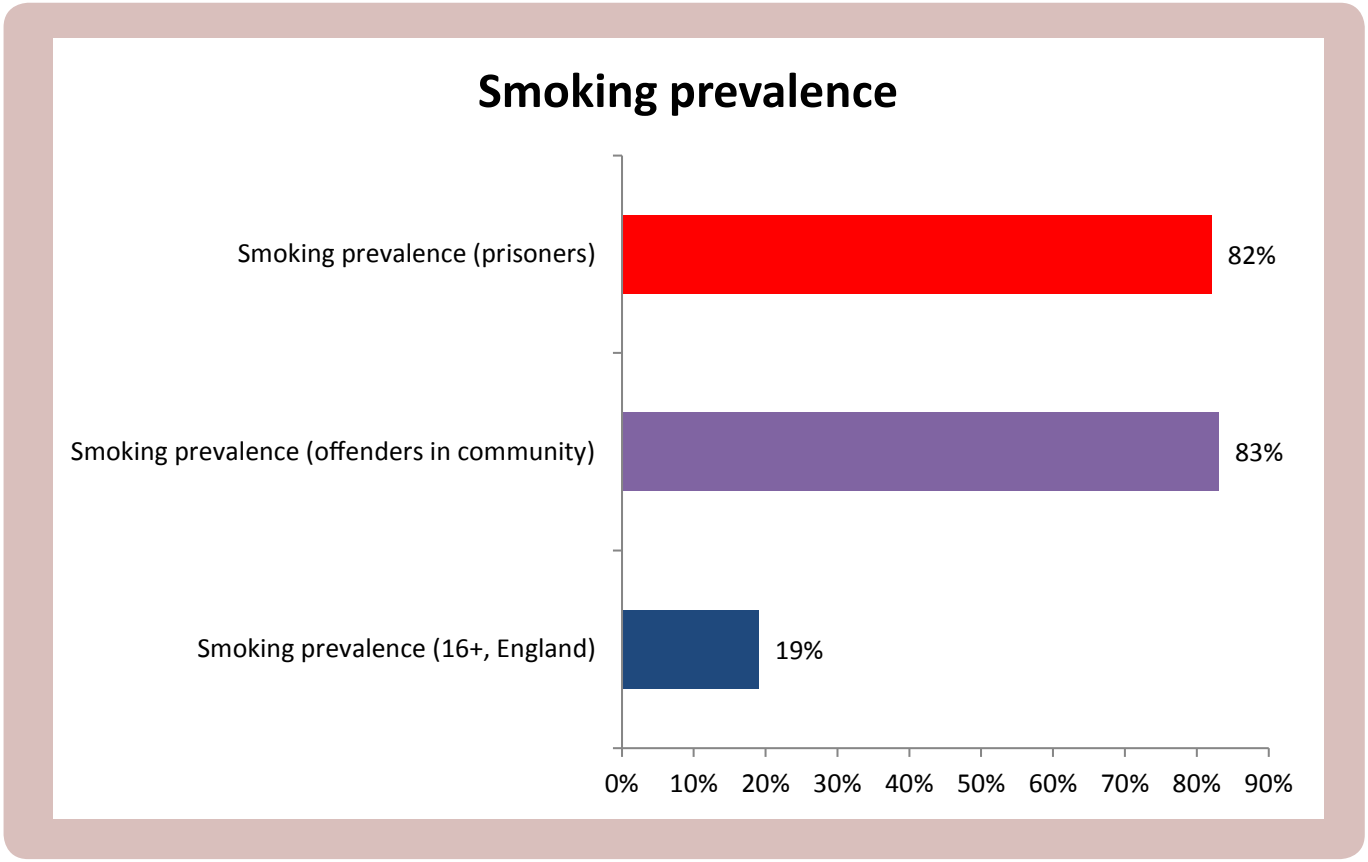
Smoking

Smoking is also far more prevalent among both the prison population and offenders serving community sentences, with both groups containing roughly four times the proportion of smokers compared to the general population.

PHE publishes the Local Tobacco Control Profiles for England, which provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level.

Parental substance misuse

Parental substance misuse can present risks to children, and can result in the involvement of social services and, in some cases, children being looked after or taken into care. There are a number of approaches that have been used to help people affected by substance misuse and related problems, including histories of or current offending behaviour, to become better parents. These have included supportive arrangements, counselling approaches and through the roll-out of Family Drug and Alcohol Courts (FDACs) which, as the name suggests, are family rather than criminal courts. The evaluation of the first wave of FDACs found that outcomes relating to substance misuse cessation and reunification were improved, and that there was the potential for cost savings compared to treatment as usual.



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Coexisting substance misuse and mental ill health

Sometimes referred to as ‘dual diagnosis’, it is not uncommon for people affected by drug and/or alcohol misuse to also experience mental ill health, and vice versa. A study from 2003 found that comorbidity of mental illness and substance misuse has been associated with increased psychiatric admission, violence, suicidal behaviour, excess service costs and poor treatment outcomes in both psychiatric and substance misuse treatment populations.

19 http://www.ncsct.co.uk/usr/pub/Smoking%20and%20mental%20health.pdf, http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf

The same study found that 44% of users of community mental health teams (CMHTs) reported past year problem drug and/or alcohol misuse, that 75% of drug service and 85% of alcohol service patients had a past-year psychiatric disorder. It should be noted though that since this study, service thresholds have altered and, in the case of substance misuse treatment in particular, are lower, and the findings of this study may not reflect current prevalence among the users of those services. Further, the study found that common mental illnesses, such as anxiety and depression, along with personality disorder, were most common. Psychotic disorders were comparatively rare.

Older People

Prisoners over the age of 50 are the fastest growing age group in the prison estate across England and Wales. It is estimated that approximately 15% of the prison population are over the age of 50, and that 80% of this group have a long standing illness or disability. This is particularly important, given the ageing prison population; the number of prisoners aged 50 and above has more than doubled in the last ten years. Older prisoners are also likely to experience an accelerated ageing process, with a physiological age ten years older than their contemporaries in the community. This group are likely to have particular health, social care and housing needs upon release that will need addressing, with continuity of care and support at prison release being particularly important.

Local authorities have, since April 2015, been responsible for meeting the social care needs of people within prisons within their areas. This change may ensure more consistency and in the provision of social care and may mean that fewer people experience unmet need.

Further, the high prevalence of physical and mental health problems among younger prisoners may result in or be accompanied by social care needs, irrespective of age.

Children, families and adverse childhood experiences (ACE)

One risk factor, conduct disorder, is relatively rare among the overall population, affecting around 5% of girls and 8% of boys aged 11-16. Despite this low general prevalence, around 80% of all criminal activity may be attributable to people who had conduct problems – a broader category encompassing the diagnosis of conduct disorder – during childhood.

Other risk factors include socioeconomic characteristics such as familial and neighbourhood deprivation but also parental characteristics such as parental offending, substance misuse and mental ill health, and relationship factors such as abuse, discord and inconsistent or neglectful parenting.[20] Helping parents in contact with the criminal justice system to be more effective parents may improve outcomes both for the adult(s) and their children. While levels of need and service responses will need to be determined locally, the priority must be to focus on the interventions that have the best outcomes, both for a young person's transition to adulthood, and for reducing reoffending.

There is robust evidence that adverse childhood experiences (ACEs) can have a sustained, detrimental impact into adult life. The types of childhood trauma generally considered to form ACEs include:

- physical abuse;
- sexual abuse;
- emotional abuse;
- physical neglect;
- emotional neglect;
- mother treated violently;
- household substance abuse;
- household mental illness;
- parental separation or divorce; and
- incarcerated household member.

20 Sainsbury Centre for Mental Health (2009) The Chance of a Lifetime: Preventing Early Conduct Problems and Reducing Crime. London: Sainsbury Centre for Mental Health

Lifetime effects have been identified, including dose-response relationships with multiple adverse outcomes, including poor physical and mental health, and offending/involvement in the criminal justice system. A recent Welsh report found that if no individuals in the population were exposed to ACEs, then the prevalence of incarceration amongst Welsh adults could be as much as 64.6% lower.

With regard to the intergenerational impact of incarceration, there is evidence that 65% of boys with a convicted parent go on to offend, that children of prisoners have at least double the risk of mental health problems compared to their peers, and that parental imprisonment can lead to stigma, bullying and teasing. Additionally, children of prisoners are often subject to unstable care arrangements, and face a negative financial impact on families, including financial instability, poverty and debt, and potential housing problems. Collectively, this constitutes substantially higher levels of social disadvantage than their peers.[21]

Black, Asian and minority ethnic (BAME) groups

Naturally, not every person from every ethnic or cultural group has the same experiences either of health and social problems or of accessing services and differences can vary according to gender, religion or sexual orientation.

In many services relevant to this briefing, people from BAME backgrounds are over or under-represented, or appear to be dealt with differently, such as the over-representation of African-Caribbean people among those entering secondary mental health services via the courts or the police, rather than through primary care. The evidence is clear from Count Me In (2005-2010) of different pathways, increased coercion and increased detention for, particularly, Black and Black British people. It chimes with the findings of lower satisfaction, understanding or trust, that may be associated with lack of engagement with services, as indicated by research by, for example the Joint Commissioning Panel for Mental Health.

- Black and minority ethnic defendants are more likely to go to prison for certain types of crime. Emerging findings from the Lammy review have highlighted that there is disproportionality in the criminal justice system. One finding was that for every 100 white women handed custodial sentences at Crown Courts for drug offences, 227 Black women were sentenced to custody. For Black men, this figure is 141 for every 100 white men. Among all those found guilty at Crown Court in 2014, 112 Black men were sentenced to custody for every 100 white men. The disproportionality analysis also found that, among those found guilty, a greater proportion of Black women were sentenced to custody at Crown Court than white women

There is evidence that ethnicity also has a role in determining experiences of the CJS, with Black and Muslim people in particular experiencing different and often worse outcomes at every step along the CJS pathway, including being significantly over-represented among the prison population. This is reflected in the findings of the Young Review, and the interim findings of the Lammy Review. Researchers with the charity Release have also found ethnic disparities in the policing and prosecution of drug offences, with Black people in particular disproportionately likely to be stopped and searched, to be charged if found in possession, and to receive a harsher sentence.

A recent annual report from HM Chief Inspector of Prisons highlighted that prisoners from Black and minority ethnic backgrounds and Muslim prisoners continue to report a worse experience than the prison population as a whole.

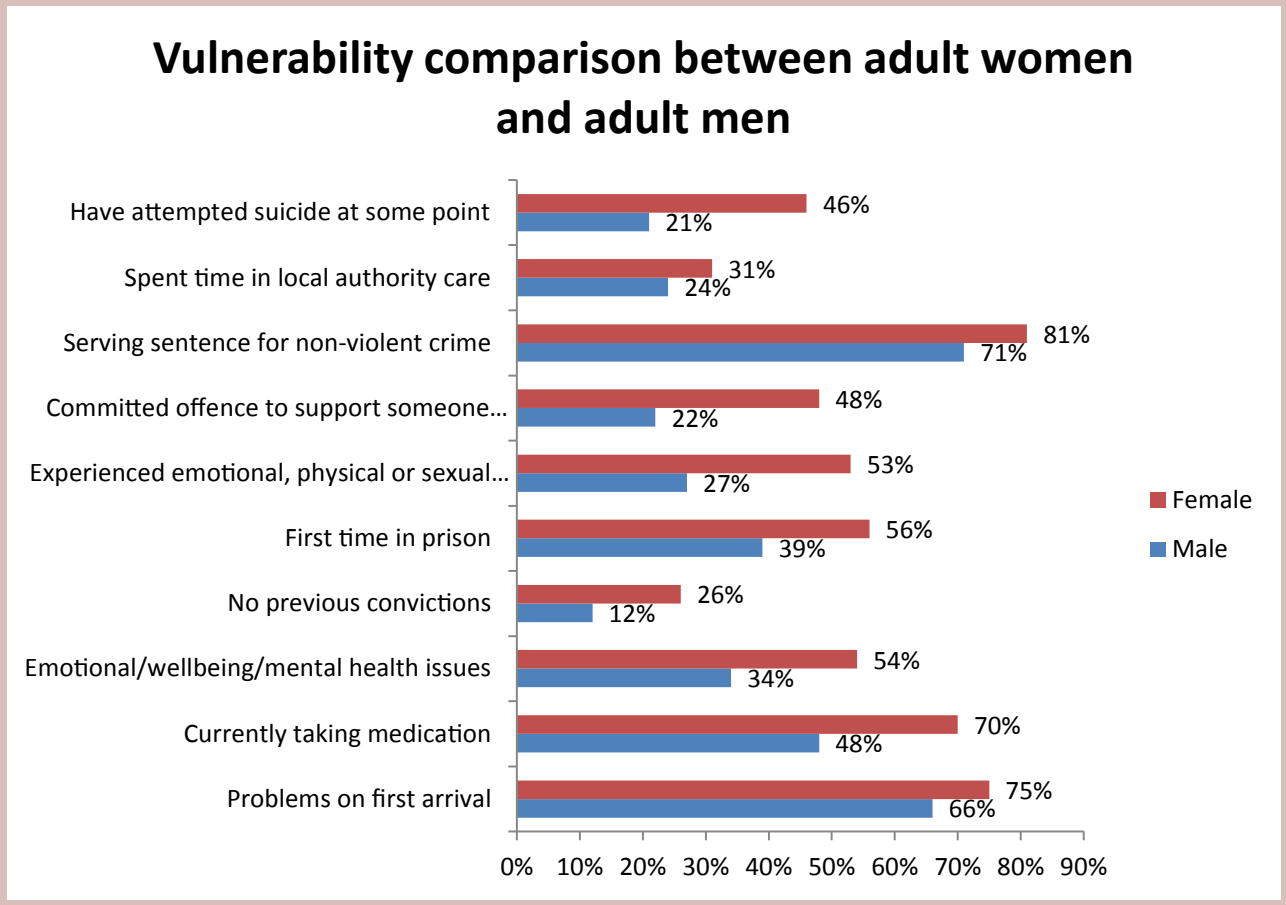
21 Farrington, D.P. and Coid, J.W. eds., 2003. Early prevention of adult antisocial behaviour. Cambridge University Press.

Women

Women involved in the criminal justice system face distinct challenges and have particular needs. As illustrated above, for some conditions, such as substance misuse, mental ill health and blood-borne viruses, there is a substantially higher prevalence among women than among men, and the research by Farrell & Marsden referred to above indicates a substantially higher risk of death (primarily drug related) for women on release from prison compared to men.

The Corston Report published in 2007 argued that equal treatment of men and women does not result in equal outcomes. Many women in the prison present a far greater risk to themselves than to others, and should be recognised as more "troubled" than "troublesome". Additionally, women are less likely than men to have someone looking after their home and family, and they are more likely to lose their home and children as a result of imprisonment: 25% female prisoners are lone parents vs. 3% male, and an estimated 17,000 children have been separated from their parent(s) due to imprisonment. Around 160,000 children per year have a parent in prison.

HM Chief Inspector of Prisons annual report 2015–16 contained a section specifically considering the particular needs of women in prison, highlighting some of the further challenges that women can face more commonly than men. The chart above highlights some differences found between the needs and experiences of male and female prisoners, including other information compiled by the Prison Reform Trust.



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Around half of women in contact with the criminal justice system are affected by domestic violence, at a cost of almost £3.5bn per year, largely shared between four groups of services: the CJS, health, social services and housing. A report published jointly by the Prison Reform Trust, the Association of

22 http://www.prisonreformtrust.org.uk/Publications/Factfile

Directors of Adult Social Services and the Centre for Mental Health highlights a number of promising approaches to meeting the needs of women who offend, including women-specific services and women-centred working.

Homelessness

Homelessness is associated with multiple health and social problems, particularly so in its most harmful and visible form, rough sleeping. Prior homelessness (including insecure housing and living in temporary accommodation) has been found to be a reliable predictor of higher reoffending, even controlling for criminal history.

A study from 2012 found that 15% of prisoners had been homeless immediately prior to custody, compared to a lifetime experience of homelessness of 3.5% in the wider population. More than three-quarters of prisoners (79%) who reported being homeless before custody were reconvicted in the first year after release, compared with less than half (47%) of those who did not report being homeless before custody. 37% of prisoners felt they would need help to find accommodation on release, with almost all of them (84%) thinking they would need a lot of help.

Data on both statutory homelessness and rough sleeping are published by the Department for Communities and Local Government (DCLG). The latter is based on spot counts and estimates, and may not reflect actual local need. In London, more comprehensive data are maintained by the Greater London Authority. Homelessness sector membership organization Homeless Link and service provider St Mungo's have produced guidance for Health and Wellbeing Boards on incorporating homelessness in JSNAs.

Providers of probation services are required to ensure that their clients are helped to access services to secure and maintain settled and suitable housing.

Key policy developments

The Prison safety and reform white paper sets out a number of ambitions for the female estate and for women who offend, highlighting that female offenders are often vulnerable, and that a specific approach may be beneficial. The paper also proposes five new community prisons; these are intended to be smaller, to be more focussed on resettlement, and to be nearer to women's homes, although they will be built on the existing prison estate.

The white paper also contains a pledge to produce, in early 2017, a women offender's strategy, setting out a plan for how the treatment of women can be improved, through early and targeted intervention, in the community and in custody. This may build on the progress made in some Crown Prosecution Service (CPS areas) of piloting conditional discharges for women in some circumstances, and other successfully piloted women's diversion schemes.

Employment support

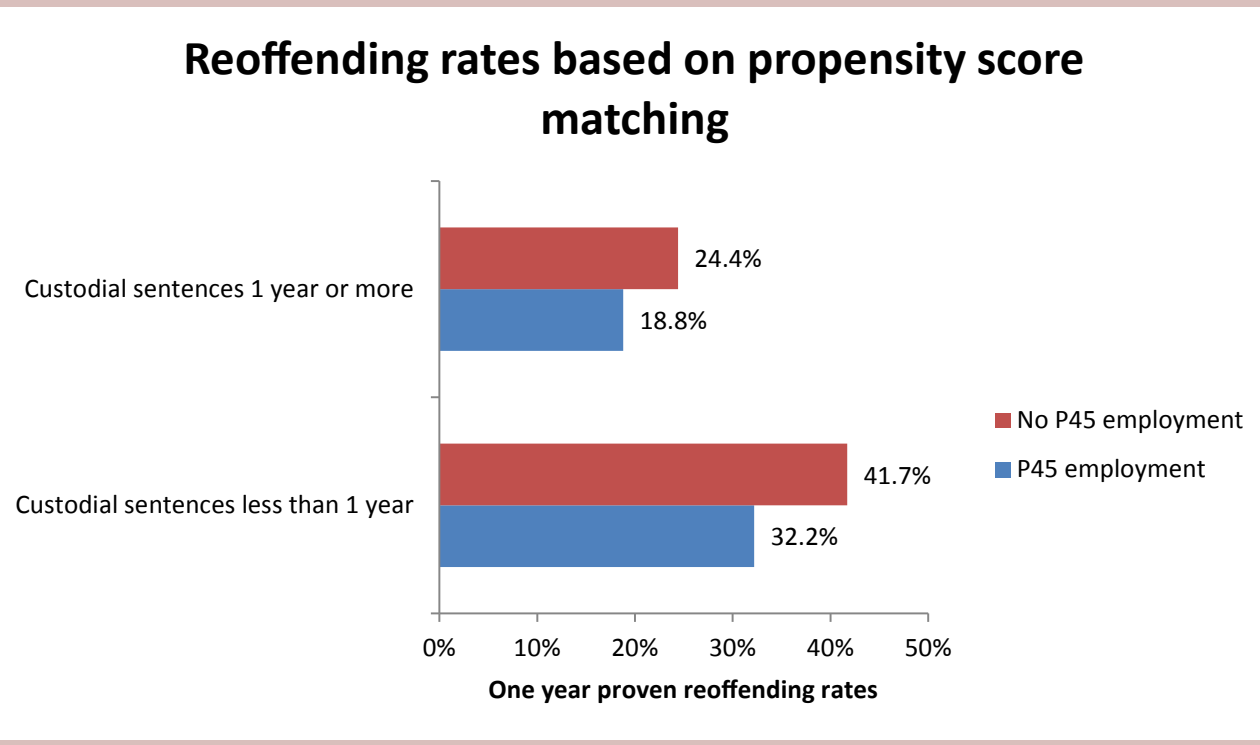
Ministry of Justice research suggests that among the prison population, pre-offence employment rates are notably low, with barely a third (32%) in paid employment in the 4 weeks before custody, and 13% reporting never having had a job at all. Average earnings for employed participants were low and substantially lower for women than for men. Almost half (48%) of the participating prisoners felt that they would need help to find work on release, a larger proportion than those who felt that they would need help with housing.

Supporting ex-offenders into employment is often regarded as a panacea. Evidence suggests that it isn't that, but that there are significant and substantial effects in reducing reoffending, both for long and short sentence prisoners.

A recent study using propensity score matching found that gaining P45 employment was associated with a 9.5 percentage point reduction in the one year proven reoffending

rate for people serving sentences of less than a year, and a 5.6 percentage point reduction for people serving a year or longer. In terms of overall reduced reoffending rates for these two groups, this would fall in the range 20-25%. In addition to associations with lower rates of reoffending, there are additional benefits to workless people securing work, including a typical fiscal saving of between £8,000 and £10,000 per person per year and can offer a wider economic value of up to around £14,000 per person per year. This can, in some cases, include a saving to health systems of over £1,000. The cost of labour market interventions can vary substantially, although most recent UK labour market programmes have fallen in the rage of roughly £1,380 (target, not achieved) to £6,500 per participant.

As well as desistance from offending, there is evidence that employment can make a contribution to improving outcomes for treatment from substance misuse, and can reduce the severity and frequency of relapse. Supporting more people from treatment into employment may provide better value for spend on treatment, 'lock in' the gains made and support additional positive outcomes, including a reduction in offending behaviour. These points are echoed in more detail in the independent review into employment, drug and alcohol addiction, and obesity, headed by Dame Carol Black.



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Social security

While most people, when they are able to, seek employment, the social security system provides vital support to people when they are unable to work for health or other reasons. There is evidence that people with health needs, including mental health needs, can require and benefit from welfare benefits advice.

The recent publication of findings from research highlights the particular challenges carried out with people with offending histories face. There is also some evidence that ESA claimants with a primary medical condition (PMC) of mental ill health and those with a PMC of drug or alcohol misuse are more likely to face a sanction (a temporary suspension of benefits[24]) than the typical claimant. There is some evidence that

23 **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217412/impact-employment-reoffending.pdf**

24 Claimants of Jobseeker's Allowance (JSA) or Employment and Support Allowance in the work related activity group (ESA WRAG), and some claimants of Universal Credit will be subject to **conditionality** – expectations on which the entitlement to benefits is based.

being sanctioned can, in addition to causing hardship and housing problems, drive some people to disengage from support services and to commit 'survival' crime.

There are aspects of UC which may be particularly challenging for some households, including people being resettled from prison. Many people, although not released prisoners, will need to wait a week before a new UC claim goes live. This means that new claimants may face around 5 weeks without any income, any means of paying their rent or, if relevant, putting down a deposit on a property. New claimants are likely to need welfare benefits advice to apply for an advanced payment, and/or may also need help to access support such as rent deposit schemes, where available.

Partnership and governance

Reforms including the introduction of PCCs, the localism agenda and multiple similar (but by no means identical) devolution deals around England have supported the long-acknowledged drive to break out of silos, to improve partnership working and to make more effective use of resources. However, this has taken place at a time when funding for public services is under sustained pressure, and has brought new complexities of its own including, for example, issues around governance and service management when a service might be both commissioned and delivered jointly, and be accountable to a wide range of stakeholders.

This section considers some of the issues, and highlights current and emerging positive practice.

Governance overview

There is now evidence of stronger arrangements for collaboration and partnership within public sector environments. Models currently vary across the country, involving joint commissioning, forms of integrated provision, and some combined structures. At their tightest these structures aspire to involve combined governance and accountability arrangements. This includes the use of common performance outcomes, supported by strong programme management with clear lines of accountability and overall programme leadership.[25]

Principles of good governance (WHO, updated 2014)

- **Legitimacy and voice:** that all stakeholders be included in legitimate process of development
- **Direction:** that a clear vision is set
- **Performance:** that measurable processes and outcomes are set
- **Accountability:** that all relevant sectors are accountable for shared goals
- **Fairness:** that the governance systems proposed involve equitable processes

When selecting goals account needs to be taken of the Public Health Outcomes Framework Indicators and the NHS Outcomes Framework. For understanding need and selecting goals, PHE produces public data on key Marmot indicators at local authority level, some of which directly concern the types of health inequalities and social disadvantage that provide a context to this agenda. This is among a suite of resources, including the wider Fingertips public health profiles and the local health profiles sites. Likewise, police crime statistics at area level can shed light on both levels of offending behaviour and can be referenced against measures of local deprivation, such as Indices of Multiple Deprivation.

In addition to published statistics, local stakeholders will have access to often richer and more granular data, and intelligence gained from providing and/or commissioning services. All of which can aid the accurate assessment of need and planning for appropriate responses.

25 Governance for health equity - taking forward the equity values and goals of Health 2020 in the WHO European Region Chris Brown Dominic Harrison Harry Burns Erio Ziglio WHO 2014

The diagnostic model used by the Health Inequalities National Support Team to identify at a local level what specific interventions are needed to improve service outcomes suggests a relatively straightforward process. Once the baseline is established (i.e. where we are), together with agreeing partnership outcome targets (i.e. where we want to get to), the process of establishing what interventions will be capable of contributing to the right dimension of change in the relevant timescale (i.e. what we need to do, and how) can be established.

The Public Health Outcomes Framework

Public Health Outcomes Framework indicators provide local areas with a set of indicators which help to describe the health of their population. There are a number of indicators which relate are of particular relevance to the health of people in contact with the criminal justice system. These include:

(The italicised indicators refer specifically to offending and reoffending.)

1.04 First time entrants to the youth justice system

1.07 Proportion of people in prison aged 18 or over who have a mental illness

1.11 Domestic abuse[26]

1.12 Violent crime (including sexual violence) (1.12i-iii)

1.13 Re-offending levels - percentage of offenders who re-offend (1.13i-ii)

1.13 First time offenders

1.19 Older people's perception of community safety

2.10 Self-harm[27]

2.15 Successful completion of drug treatment

2.16 *Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison*

2.18 Alcohol related admissions to hospital[28]

2.23 Self-reported wellbeing

3.4 People presenting with diagnosis at a late stage of infection

4.3 Mortality rate from causes considered preventable

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

26 Indicator shared or complementary with **Adult Social Care Outcomes Framework**

27 Indicator shared or complementary with **NHS Outcomes Framework**

28 As above

Place-based system for planning

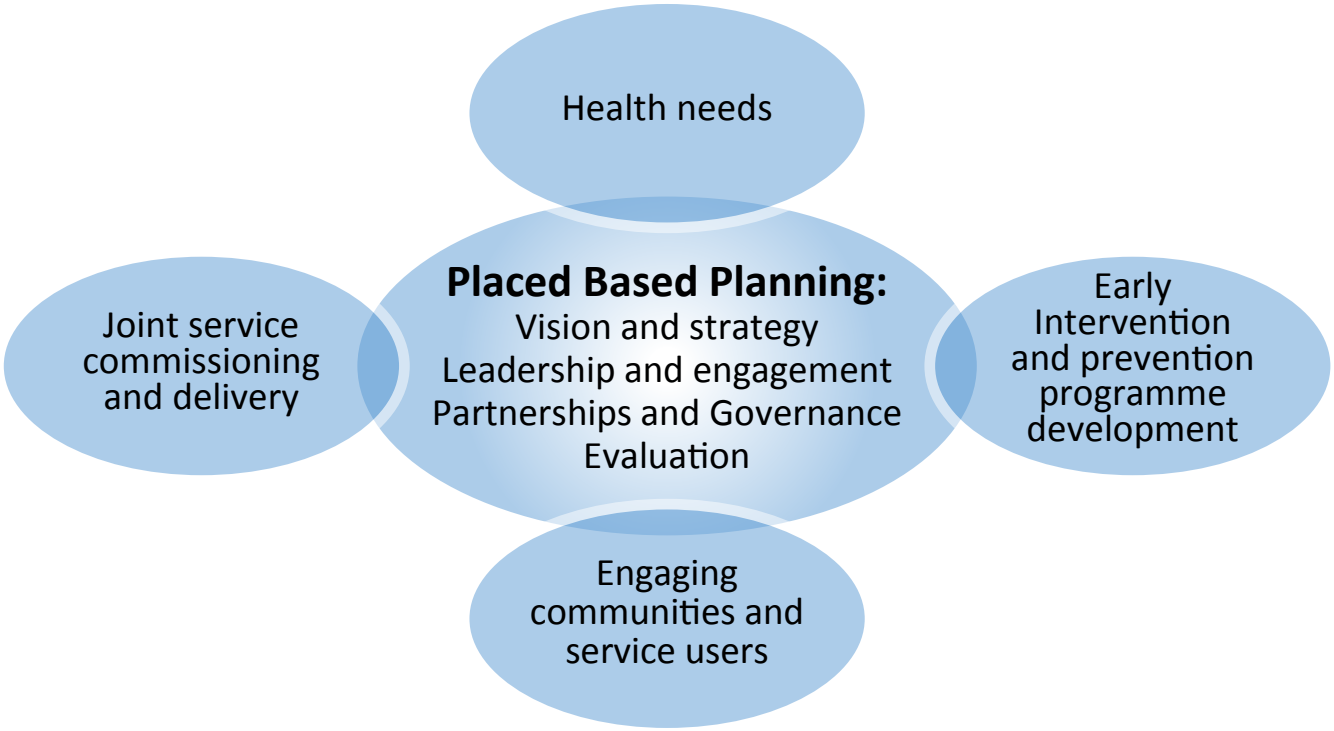
Health inequality has long been known as a 'wicked issue' i.e. one with complex causes which require complex solutions[29], including a whole systems approach, with strong systems leadership. A placed based approach provides an opportunity within which to do this.

Experiences from the Health Inequalities National Support Team identified the need for an 'organising hub' to provide a strategic focused approach to tackling these complex issues and achieve population level outcomes.

The following provides detail of key components required 'within the hub' to ensure a strategic approach in the development of a plan of action to tackle health inequalities and reduce offending.

Leadership and systemic engagement are needed to drive a strategic approach to this agenda to ensure system, scale and sustainability. The most promising examples identified have tended to feature the leadership of a partnership by one or more key partners. Whether this leadership sits

29 David J. Hunter, Professor of Health Policy and Management J Public Health (2009) 31 (2): 202-204.



within the health system, the criminal justice system or elsewhere may be immaterial, but leadership – and ownership – appears to be a consistent factor for successful programmes with positive outcomes.

The leadership challenge is to both understand the nature of the policy and organisational contexts within which addressing health inequalities and reducing offending and reoffending are being promoted, and to encourage and shape new ways of tackling the problems.

Identifying key stakeholders who can inform local decisions

Developing programmes across health, justice and related services involve working across complex commissioning and funding lines.

Key stakeholders who can contribute to a place-based planning hub might include:

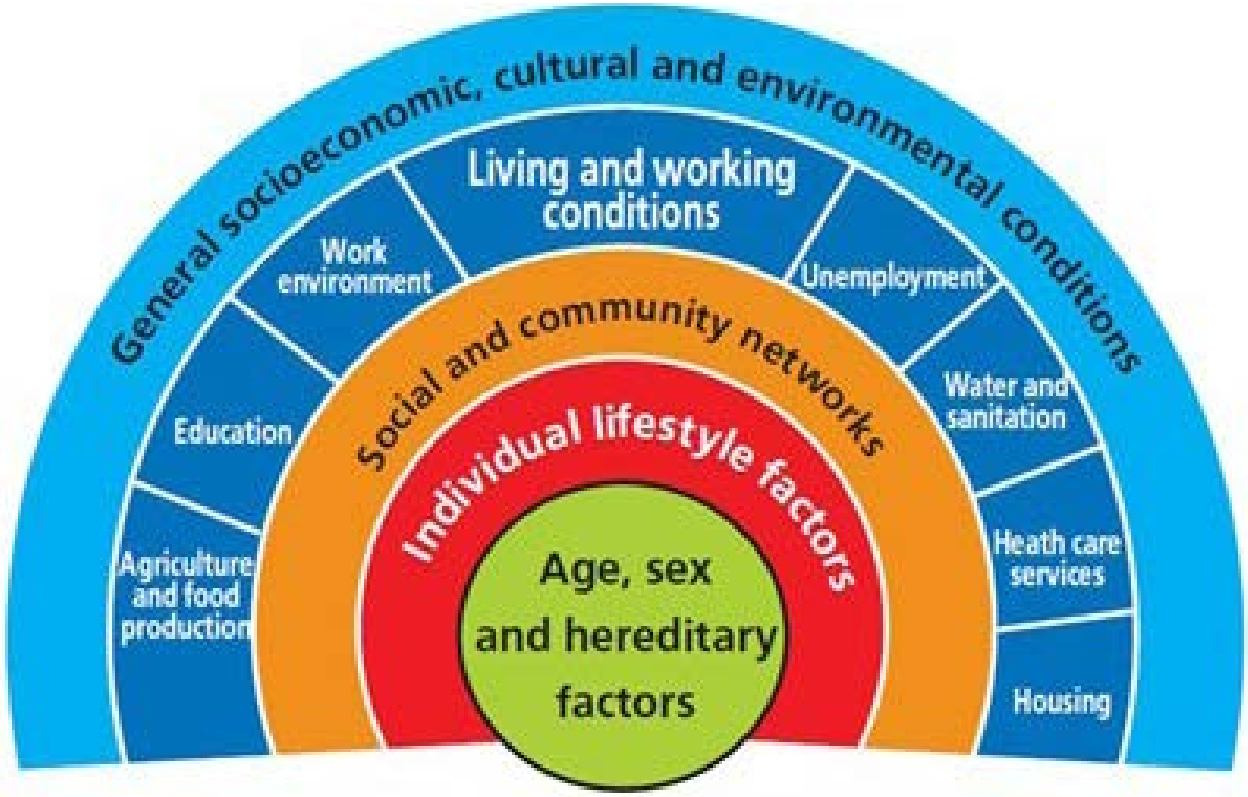
- **Police and Crime Commissioners:** commission police custody healthcare services, and more. Priorities are set out in local Police and Crime Plans and may include targeted interventions for substance misusing offenders, services or interventions aimed at particular sub-populations, and services for victims. Their role is expected to expand, although the expansion may vary depending upon local need and capacity, and devolution agreements. Irrespective of the expansion of their role, PCCs can play a critical role in ensuring that offender health issues and needs are being tackled locally.
- **Directors of Public Health:** The Director of Public Health has a lead role in improving the health and addressing health inequalities of the people in their local authority area. They are a statutory chief officer of a local authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health. They have a specific role to work with local criminal justice partners and police and crime commissioners to promote safer communities.
- **Local authorities:** commission drug and alcohol services as well as being

statutorily responsible for community safety, including safeguarding vulnerable adults and children. In addition to revenue raised locally through council tax, business rates and commercial activity, local authorities receive revenue funding from central government. This includes a ring-fenced public health grant, which provides for funding of substance misuse treatment and other local activity to improve the public's health. Moves to a new funding regime, based around 100% retention of business rates will offer some areas opportunities, but may leave areas with limited local business economies facing new challenges.

- **Existing partnerships and collaborative bodies including Community Safety Partnerships (CSPs) and Youth Offending Teams (YOTs).** Each CSP includes the local authority, the police, fire service, probation services, health authorities, the voluntary sector, as well as local residents and businesses. The main Partnership board may divide into working groups covering specific subjects such as antisocial behaviour, reducing reoffending and substance misuse. YOTs have the local authority, the police, probation services and clinical commissioning groups as statutory members. Additional members may be recruited, including, for example, from education, housing and the voluntary sector.
- **Other, non-mandated local multi-agency partnerships**, such as community multi-agency risk assessment conference (MARAC) (which takes the multi-agency risk assessment conference pioneered in responding to domestic violence and extends it to vulnerable people) and MAPPA (multi-agency public protection arrangements).
- **Clinical Commissioning Groups** commission the majority of healthcare services in the community, including for people in contact with CJS in the community. They have a statutory duty under the Crime and Disorder Act 1998 to work in partnership to reduce crime and disorder, substance misuse and re-offending locally, as well as duty to reduce health inequalities, including those experienced by offenders.
- **NHS England Health and Justice Commissioners** who commission healthcare provision including Liaison and Diversion, and healthcare for those in secure and detained settings; in contracted-out prisons, the National Offender Management Service (NOMS) commission's primary care services only.
- **PHE centre health and justice public health specialists** who provide leadership at PHE centre level to the Health and Justice agenda, supported by a National Health and Justice team within PHE.
- **Other stakeholders from local authorities, e.g. housing, children's services and adult social care:** people in contact with CJS living in the community may have significant housing needs, and released prisoners often require housing advice and support. From April 2015, local authority adult social care has been responsible for assessing and meeting the needs of people in prison.
- **Probation services,** divided into **community rehabilitation companies (CRCs)** which work to meet the needs of offenders referred to them, including people serving community sentences, and released prisoners who have been assessed as low to medium risk and the **National Probation Service (NPS)** which assesses risk level of prisoners and offenders, and provides pre-sentence reports, supervises higher risk offenders and manages approved premises. It also informs local authorities of health needs of local offenders, particularly around the provision of treatments required as part of some community orders.
- **Third sector services, including user and family representatives.** Many third sector (primarily community groups, charities and social enterprises) may already be connected through some of

the partnerships outlined above. Where they are not, consideration should be given to if and how they should be engaged; third sector services and community groups often engage people who may be difficult for public services to retain contact with.

- **Prison governors.** In addition to their current responsibilities, the prison safety and reform agenda will empower governors and give them more autonomy over the services provided in prisons, including moving to a model of co-commissioning health services with NHS health and justice commissioners and a responsibility for reforming offenders to prevent more crimes from being committed; and preparing prisoners for life outside the prison
- **Chief police officers and the police service:** all police officers, and chief officers in particular, have the ability to provide valuable intelligence and data and also to drive change across their service.
- **Jobcentre Plus and DWP employment support providers.** As well as delivering services itself through the Jobcentre Plus network, DWP commissions providers to provide support to those seeking work. The two main current labour market programmes are Work Programme and Work Choice. In 2017, these will be replaced by the Work and Health Programme, which is intended to provide support to those with health-related barriers to employment, as well as the very long-term unemployed. The Work and Health Programme will be supported by a very substantially reduced budget compared to the predecessor programmes, and local authorities in particular are expected to play a larger role, particularly in devolution areas, where co-design and co-commissioning (the latter only in Manchester and London, at the time of writing) will feature.



The Determinants of Health (1992) Dahlgren and Whitehead

Early Intervention and prevention programmes

Public Health England has developed a public health model for health and justice – this aims to address both upstream and downstream determinants of offending and reoffending:

Early intervention can be understood by:

- Intervening early in the life course and/or
- Intervening early after contact with the criminal justice system first occurs

Either of these options can be effective, if targeted appropriately and used as a means of providing evidence-based interventions.

NOMS Seven pathways to reducing reoffending

In 2004, NOMS published a National Reducing Re-offending Delivery Plan, based on seven pathways to reducing reoffending. While this document is no longer current, the pathways comprise a holistic set of measures, with the overarching theme that reducing reoffending can only be achieved through partnership working and addressing 'the causes of the cause'. Some examples of how partners can meet the pathway objective are included, and the importance of holistic approaches that recognise the need to improve social inclusion across a number of domains:

Pathway to reducing offending	Partnership activity
1. Accommodation – the foundation of rehabilitation and a springboard	Specialist support, identified pathways into accommodation, homeless hospital discharge programmes
2. Education, training and employment – many offenders have very poor experience of education and no experience of stable employment	Economic regeneration, education and skills agenda, employment support
3. Health – problems accessing health and social care to lead to social exclusion and increase the risk of reoffending	Mental health Forensic Mental Health Practitioner (FMHP), GP registration, health outreach
4. Drugs and alcohol – the CJS is uniquely placed to tackle substance misuse and break the cycle of reoffending	Specialist community services, Drug Interventions Programme-type activity
5. Finance, benefit and debt – many offenders have financial problems linked to their offending	Credit unions, housing benefit (until universal credit), welfare benefits advice
6. Children and families – can play a role in starting and sustaining change, although many offenders have difficult and fractured relationships, increasing the likelihood of offending, mental health and financial problems	Troubled families, Early intervention, Children's public health (public health nursing 0-19 years)
7. Attitudes, thinking and behaviour – using the international evidence-base[30] on the effectiveness of cognitive skills programmes for offenders.[31]	Mental health promotion, confidence building, targeted programmes

30 For a review of key literature relating to recovery and desistance, see Terry L and Cardwell V. 2016. Understanding the whole person. London: Revolving Doors. Available at **http://www.revolving-doors.org.uk/documents/understanding-the-whole-person-part-one/**

31 National Offender Management Service. 2004. National Reducing Re-offending Delivery Plan. London, National Offender Management Service

Engaging with communities & service user involvement

The NHS Five Year Forward View sets out how our health services need to change and argues for a new relationship of engagement with patients and communities. Although challenging, it is even more pertinent for people in contact with the CJS who are often underserved by current services. Engaging with this population will ensure services are developed around the person's needs rather than fitting around the needs of a service. However good these services are, if they do not connect with this population effectively, this population will not benefit from them. Therefore, activity to improve services need to be balanced with ways to support effective engagement with them.

The health and wellbeing guide to community centred approaches outlines further information about evidence-based community-centred approaches to health and wellbeing.

This approach can dovetail into existing systems that organisations have to reach underserved populations, including through existing community groups or support services, for example through health trainers, community ambassadors and community health educators.

One of the most important ways a service can engage with its users, where relevant

and appropriate is through service user involvement and engagement. This can be employed as a means of designing and commissioning services, of contributing to governance arrangements, and of gaining user feedback on a 'live' basis as a means of constantly monitoring and trying to improve service provision.

User involvement, including peer research, in health and justice settings is an expanding and developing area where many examples of innovation can be found. Some of these have been identified by Revolving Doors Agency in its toolkits produced on behalf of NOMS, and in an a recent resource published jointly with Clinks. Other resources have been produced by Clinks and, focussing specifically on commissioners of substance misuse services, PHE.

Some key principles include:

- prisoners and offenders can be partners in public health;
- health needs assessments, joint strategic needs assessments and health service evaluations need to take account of prisoners' and offenders' voices if they are to be truly useful in delivering effective and efficient care;
- prisoners and offenders can be part of the solution in designing and delivering health promotion and health improvement programmes
- peer educators can be a much more effective means of engagement, and peer-modelling can promote more effective uptake of positive health behaviours, such as smoking cessation;
- sustaining change beyond the prison gate is possible, and positive change can be driven by actions of ex-prisoners.

Commission jointly with partners across the system

Like data, commissioning and funding lines are often fragmented and spread across several systems. This section sets out a number of ways, through examples of practice, in which stakeholders can come together to meet the health needs of local people in contact with, or at risk of becoming in contact with, the criminal justice system.

Effective pathways need good data mangement to monitor patient and service user flows through and across systems, and to reduce the bottle necks which contribute to people falling through gaps. NHS Digital's collaboration with NHS England to produce the Health and Justice Information Services will help to integrate the flow of referrals and information between parts of the prison estate and between community services. This work is already being taken forwards in the case studies highlighted here, including in Essex and London. Both examples illustrate how how active partnerships between prison-based healthcare, community healthcare and offender management can make susbtantial gains in improving continuity of care.

Integrated care pathways

People, particularly those with complex needs (compounding social determinants; clustered risk behaviours; multi-morbidity), are likely to become engaged in multiple 'pathways' of care which cross disciplinary and organisational boundaries.

Therefore, integrated pathways supported by joint commissioning and joint service provision are recognised approaches to overcome this. But for services to be fully accessible to this population they need to be planned to overcome practical issues, for example, uncoordinated care and action plans which suit service providers rather than users and conflicting appointment times in locations unsuitable for the person. Further, it is known that people who are disadvantaged due to health and/or social needs typically have difficulty in navigating and negotiating traditional healthcare settings, and they may consequently engage poorly or drop out of services. To ensure maximum effectiveness, services themselves also need better access to coordinated data and information, a shared understanding of issues and better coordinated action plans, but also a

commitment to listening to and learning from their clients, and using that information to ensure that they provide genuinely accessible services.

Return on investment

There are many evidence-based and robustly evaluated interventions and treatments available for many of the health and social problems highlighted in this resource. As interest has grown in recent years about not only the effectiveness but also the cost effectiveness of treatments, services and interventions, attention has increasingly fallen on return and social return on investment, the realisability of cashable savings, and to where savings accrue.

Alongside service evaluations, trials and pilots, a range of resources have developed which can assist local leaders to gain a better understanding of the economic and financial consequences of their actions. These include the Cabinet Office-backed unit cost database and cost-benefit analysis resources from New Economy Manchester, as well as various resources produced, primarily for local authorities, by Public Health England. Internationally, institutions such as Washington State Institute for Public Policy maintain regularly updated resources that provide high quality evidence to inform local decision making. While the Justice Data Lab from the Ministry of Justice estimates effectiveness only, some organisations have used the voluntary organisation Pro Bono Economics to use the Data Lab outputs to develop an understanding of the costs and benefits of their intervention.

An example of an evidence-based intervention that is proven to reduce offending and to provide a positive return on investment is substance misuse treatment. A 2008 study by the National Treatment Agency (now absorbed into PHE) which compared criminal charges against a cohort of people who misuse heroin and/or crack cocaine in the 12 months pre-and post-treatment start found a 48% reduction across a range of criminal charges. Overall, treatment for adult drug misuse provided a return of £2.50 for each pound spent, while each pound spent on young people's drug and alcohol services returned between £5 and £8.

However, there have been historical challenges in making a business case based solely on return on investment. In many cases, the savings are not cashable, or accrue to someone other than the entity funding the intervention. For example, a local authority funding a labour market programme (as many do) is likely to find that little of the quite substantial savings generated by a workless person moving into work accrue back to it. While the challenges of building a robust, evidence-based case for pooling funding are formidable, new commissioning and funding arrangements across health, justice and related services have resulted in somewhat lower barriers to doing so.

Coordinated services – examples of positive practice

Several areas at different geographical levels have adopted approaches that address many of the needs and gaps identified in this briefing. Other countries, including the Netherlands, have also introduced innovative examples of positive practice, although it is less clear how they might translate to the UK.

Other examples of collaboration and partnership have been highlighted in PHE's recent briefing, Police and Public Health.

Essex Full Circle

In 2010, Essex County Council (ECC) and partners started the process of transforming the provision of community drug treatment with the intention of providing greater continuity of care. In the process, the improved pick-up rates between community and prison drug treatment to 62%, above the national figure and among the highest rates in the country. In 2016, they have implemented Full Circle, a service that adopts the successful drug treatment approach and integrates alcohol misuse, mental health and learning disabilities.

Pan Essex Health and Justice Commissioning

To inform appropriate commissioning decisions in relation to services to address health inequalities and in particular to address specific pathways in relation to health, social care, drugs and alcohol and to support reductions in re-offending rates and improvements in health and wellbeing, a number of research projects were commissioned by ECC Public Health. To support the implementation of these reviews, a multi-agency working group comprising local authority representatives, the clinical commissioning group, the CRC, the local prison, NHS England and the OPCC was established. The work of the group has included: significantly redesigning substance misuse provision locally, reviewing the local Liaison and Diversion and Street Triage offers, provision of appropriate adults, resettlement and access to accommodation for offenders. This work built on, or directly connected to, building on and further developing links to the NPS, IOM, multi-agency public protection arrangements (MAPPA), youth offending service (YOS) and domestic abuse agendas to ensure further streamlining and efficiency was achieved.

London GP Registration for Offenders Scheme

People who come into contact with the criminal justice can, as outlined above, have multiple barriers to effectively accessing mainstream services. These can include being of no fixed abode (i.e. homeless), literacy problems and chaotic lives that can make remembering and keeping appointments difficult, and can contribute to some people becoming indifferent to their own health. Aimed primarily at people released from prison, this scheme aims to reduce health inequalities by ensuring that, as part of their reintegration to their communities, ex-offenders are registered with a local GP. Where a person is homeless, their registered address for GP registration purposes can be their probation office, youth offending team or substance misuse service, staff of whom can also confirm the person's identity. The staff of those services can also identify people without a GP, and (with consent) can make a referral. These principles have been agreed with NHS England and incorporated into the GP Patient Registration Standard Operating Principles for Primary Medical Care.

Amsterdam Top600

Providing integrated services to address unmet needs and inequalities, reduce reoffending and improve public safety has been a priority for health, justice and social support organisations around the world, not just in the UK. The Top600 initiative, spearheaded by Amsterdam City Council, involves identifying and working with the 600 highest impact offenders in the city, and is based on collaboration and partnership between the council, the criminal justice system, health and care services, and the voluntary sector. In this collaborative approach, Top600 is similar to IOM, but it differs in important respects. The three core principles are: 1 'tit for tat' – consistent and severe sentencing; 2 care – based on screening the offender's psychological state, intellectual capacity and living patterns, and; 3 influx restriction – interventions with the family, in particular the siblings, with an emphasis on the complete living environment.

Leicestershire Integrated Vulnerability Management Initiative

The Integrated Vulnerability Management Initiative (IVM) is being led by Leicestershire Police in conjunction with the Office of the Police and Crime Commissioner to improve partnership working to manage vulnerable people with complex health needs who regularly seek out policing services. The project, which will be run under the governance of the Mental Health Partnership Group, aims to generate co-commissioned services, such as substance misuse (co-funded with local authorities) and focuses on demand reduction by targeting those members of the public who regularly come into contact with police as well as improving services for vulnerable people and victims of crime.

West Midlands Violence Prevention Alliance

The West Midlands Violence Prevention Alliance (WMVPA) is an alliance of organisations in the West Midlands sharing the priority of preventing violence and was established by Public Health England West Midlands and West Midlands Police. Violence is a public health issue, and through taking a public health approach to prevention, work is guided by the evidence of what works in tackling root causes. It uses a strong evidence base and shared intelligence to identify where violence is most likely to occur, who the victims and perpetrators are, and the costs and consequences. Importantly, it heralded a new collaborative approach between public health and police in the West Midlands – building a combined understanding and undertaking a coordinated response to prevent and respond to the risk factors associated with violence. This has included establishing the West Midlands Injury Surveillance System, enabling rapid and effective communication of intelligence between health and police services. The Alliance has also partnered with schools to implement a peer led programme promoting positive friendships, relationships and respectful school cultures, and developing peer leadership. Feedback from schools on the impact on pupils and the wider school culture has been excellent, with an evaluation ongoing. Engaging health partners has been another key strand, including working with commissioners to extend the provision of the IRIS scheme in primary care (an evidence-based programme linking domestic violence advocates to GP practices) and making plans for 2017-18 with acute trusts for interventions to locate workers in A&Es to work with people where violence/ abuse may be behind their presentation.

Surrey County Council High Impact Complex Drinkers Pilot

In 2014 Surrey County Council's Public Health Team became a partner in Alcohol Concern's Blue Light Project which aimed to better address the impact of change resistant drinkers. An early task was to carry out a modelling exercise to estimate the number of individuals in Surrey who might meet the high impact, complex drinker's criteria. These criteria are: alcohol dependence; high impact on public services; and non-engagement with treatment. It was estimated that over 2000 people, in touch with a range of different services / partner forums (MARACs, police, A&E etc.) were likely to meet those criteria. However, it is highly likely that these estimates will double-count people as they may be known to more than one service, therefore a conservative estimate of 15-20% of these figures would still present a level of need of between **300-400 people**. The Blue Light approach aims to develop partnerships that require limited investment alongside using existing resources more effectively; achieving the greatest impact by bringing organisations together, refocusing what their actions; and building bridges with partners such as the police, housing and social care. Based on a selected number of referrals during the pilot, the evaluation tracked the pre- and post-referral A&E costs and estimate that each pound spent resulted in a potential saving of £4. Partner services reported that barriers to further progress included problems with accessing mental health services and housing. The pilot was unable to track the impact on the criminal justice and community safety, though evidence suggests that savings to the criminal justice system would be between 50% and 100% to those of the health care system. The next phase of the pilot, due to begin at the start of 2017/18 will be delivered in partnership with the Office of the Police and Crime Commissioner and therefore will seek to measure the impact across health and social care and the criminal justice system. For the full evaluation report please click here and for the key messages and future directions here.

Bringing it all together

This briefing has set out the policy context, the case for change, and provided some examples of how some areas are starting to work together to meet some of the challenges highlighted here. While the projects differ in their scale, their ambition, their

commissioning and funding arrangements, and even their nationality, there are some consistent characteristics that it is worth considering. These include collaboration and effective relationships; aspiration – an understanding of the problem and an evidence-based understanding of how to tackle it; information and intelligence sharing; all backed with robust and transparent governance arrangements.

Relationships are a central feature of successful systems, and need to exist on many levels, vertically and horizontally. This can include between services, and the people who use them; between service and commissioner, and between different services. It can also mean relationships between employees and employers, between different tiers of government and with separate institutions such as Police and Crime Commissioners, and between people. This last is perhaps the most important – having, for example, service level agreements and protocols in place is one thing, ensuring that they're used by the people who need to use them is another.

Aspiration can, as we have highlighted here, can be grounded in collaboration to build a more detailed understanding of local need and provision, through commissioning specific reviews, or by other means. The crucial point is that it established a sense of direction and should always provide a means of identifying when, and where, progress is being made. Learning where obstacles lie is central to effective services too, and having a clear, evidence-based theory of change and robust, external evaluation, can help to overcome such obstacles. As with relationships, defining aspiration is a conversation that people who use services and, where relevant, their families and communities should always be involved in.

With the increased drive to break out of silos and to make the most effective use of scarce resources, governance is an increasingly common factor in partnership arrangements. It is important that collaborations, partnerships, programmes and projects have clear agreed terms of reference and lines of accountability. It is essential that partnership members have a shared and clear understanding of roles and responsibilities individually and collectively, that they develop programmes of work with associated risk registers. Above all, it is essential that they are accountable to the people and communities they serve.

Appendix

Detailed overview of commissioning, legal and regulatory responsibilities

The table below is correct at the time of publication. Commissioning arrangements are complex, subject to change and may vary from area to area, particularly as the process of devolution deals rolls out and the proposed extensions to PCC responsibilities become clearer.

A regularly updated list of key health contacts, including contact details, is also provided by Regional Voices, available here: http://www.regionalvoices.org/whoswho

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
Health	**NHS England Health and Justice teams**	Commission all health services in prescribed places of detention (PPD), including mental health and substance misuse treatment. This covers: • Public sector prisons (including youth offender institutions) • Children and young people's secure settings • Immigration detention and removal centres • Sexual assault referral centres • Criminal Justice Liaison and Diversion services Note that in contracted-out prisons, primary care is commissioned by the **National Offender Management Service** (NOMS).	To *"obtain the best health benefit within available resources by commissioning high quality, safe and effective care in secure and detained settings in accordance with the NHS Mandate."* (Health and Justice Commissioning Intentions, 2016/2017) Aim to work closely with CCGs and Local Authorities to ensure effective transition and continuity of care on release from custody into the community.	10 regional teams across England. Contact your local health and justice area team lead.

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
	Public Health England (PHE) Centres	Provide expert public health advice, support and services tailored to local needs. Health and Justice public health specialists at each centre support local commissioners to understand the health needs of people in contact with the criminal justice system, both in custody and the community. This includes: • Providing advice and support to directors of public health on health and justice issues • Supporting NHS England Health and Justice Teams in the delivery of their public health objectives in custodial setting.	To help improve care pathways inside prison and 'through the gate', by providing advice and support to commissioners and providers of health and social care services in the community and NHS England Health and Justice teams.	9 local centres split across 4 regions. Each centre has a health and justice specialist.
	Public Health England National Health and Justice Team	The national health and justice Team works to deliver PHE's mission statement on health and justice which aims to reduce health inequalities, reduce offending and re-offending behaviour, support people in living healthier lives, and ensure the continuity of care from custody to the community.	The Team works in partnership with health and social care commissioners, service providers, academic and third sector organisations, international partners and prisoners/ detainees to identify and meet the health and social care needs of people in prisons and other PPDs, as well as those in contact with the CJS in the community.	Contact details for national and local Public Health England health and justice specialists.
	Clinical Commissioning Group (CCGs)	Commission the majority of healthcare services in the community, including: • Mental health care services, including psychological therapies • Learning disability services • Speech and language therapy • Out of hours primary medical services	Have a duty to have regard to the need to reduce inequalities in access to health services and the outcomes achieved for patients. They have additional duties around the integration of health and social care and related services where they consider this would reduce inequalities.	Some CCGs will have a relevant lead with offender health in their remit, however the structure varies.

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
		• Accident and Emergency and ambulance services • Elective hospital care. Responsible for healthcare services for offenders in the community as part of the wider population.	The NHS outcomes framework includes indicators relating to health issues that are disproportionally prevalent among those in contact with the criminal justice system, including reduced self-harm, addressing mental health needs, and reducing alcohol related admission to hospital. Local priorities set as part of JSNA and JHWS process (see Health and Wellbeing Board). Under the Crime and Disorder Act 1998 CCGs are a responsible authority and have a statutory duty to work in partnership with other responsible authorities and co-operating bodies to tackle crime and disorder, substance misuse and re-offending locally.	A full list of CCGs is available here.
	Local Healthwatch	Consumer champion on health and social care services. Gathering experience of local people to influence commissioning, provision and scrutiny of health and social services Raising awareness amongst commissioners, providers and other agencies about the importance of engaging with local communities. Healthwatch is delivered locally within each local authority area, supported by a national consumer champion, Healthwatch England.	Ensure the voice of health and social care service users, including the most vulnerable, is heard in the commissioning and delivery of local services.	The Healthwatch representative on the HWB will be a key contact. Healthwatch services are provided by a range of different organisations across the country. A list is available here.
Local Authority	**Health and Wellbeing Board**	Bring together representatives from across local government, the CCG(s), local Healthwatch, and partners to coordinate their commissioning processes. Develop a Joint Health and Wellbeing Strategy (JHWSs), setting local priorities to address these identified needs.	Improve the health and wellbeing of the local community and reduce health inequalities. Specific priorities set through the JSNA and JHWS process. Statutory guidance encourages HWBs to engage with, and consider the needs of, some vulnerable groups including offenders.	DPH is a statutory member of the Health and Wellbeing Board.

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
	Director of public health (DPH)	Protecting and improving the health and wellbeing of the local population and reducing health inequalities. Responsible for providing a public health intelligence service to the CCG and across the local authority, and working with key partners as a statutory member of the HWB. Direct commissioning responsibilities include: • Community-based drug services, including prevention and treatment • Alcohol misuse services, including prevention and treatment • Sexual health (including contraception services not covered by GP contract; sexual health advice and prevention; and testing and treatment of sexually transmitted infections) • Blood borne virus testing in community services (including hepatitis B and C and HIV) • Public mental health (mental health promotion, mental illness prevention and suicide prevention) • Smoking cessation services	Improve the health and wellbeing of the whole local population, and reduce inequalities in health. Specific local priorities are set through the JSNA process, but the Public Health Outcomes Framework sets a range of outcomes across four domains: health improvement; health protection; preventing premature mortality; and addressing the wider determinants of health. The indicators chosen give DsPH a direct interest in priorities such as reducing reoffending and violent crime.	n/a
	Director of Adult Social Care	Safeguarding vulnerable adults, and providing support (including supported accommodation, where appropriate) to adults with an identified care need. This includes those with a learning disability and severe and enduring mental health needs.	The Adult Social Care Framework sets out four overarching aims of: ensuring quality of life for people with care and support needs; delaying and reducing the need for care and support; ensuring that people have a positive experience of care and support; and safeguarding adults whose circumstances make them vulnerable.	Director of Adult Social Care

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
		Provide Approved Mental Health Professionals (AMHP) with specific roles under the Mental Health Act. Assess and meet the eligible social care and support needs of prisoners as well as residents in approved premises and those in bail accommodation. Responsible for providing social care for people in prisons in the applicable local authority area.	These are all relevant to offenders with a learning disability or care need, while a number of other relevant indicators, including levels of domestic violence and elderly people's perception of crime, overlap with the Public Health Outcomes Framework.	
	Director of Children's Services	Responsible for education and children's social care (CSC). Local authorities (and named statutory partners) are required to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. Responsible for meeting needs relating to a 'child in need' (i.e. a child that needs additional support to meet their potential) and a 'child in need of protection' (i.e. where they have 'reasonable cause to suspect that a child … is suffering, or is likely to suffer, significant harm'). Local Safeguarding Children Boards are required in each local authority area. Each board must have an independent chair, who should work closely with all LSCB partners and especially with the Director of Children's Services.	Services offered as part of CSC may include: • Services for looked-after children, including fostering and residential care • Court liaison and advisory services • Adoption • Child protection • Family support • Services for children with disabilities. Local authorities also have some responsibilities to young people over 18 years – for example those with disabilities and those who have been 'looked-after'. Local authorities are also responsible for care leavers aged between 18 and 21 who become homeless.	

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
Criminal justice	**Police and Crime Commissioners (PCC)**	Directly elected decision makers, responsible for strategic direction of policing with a broader community safety remit. Key duties include: • Engaging with the public • Setting local policing and community safety priorities • Holding the chief constable to account • Commissioning services for victims of crime • Working in partnership to cut crime and reduce reoffending The role is likely to expand to include Fire and Rescue commissioning, with the potential for wider criminal justice powers in the future.	To reduce crime and reoffending, and maintain an efficient and effective police force. Specific local priorities are set out in the local Police and Crime Plan.	The structure of PCC offices varies, although some have a health lead and most have a commissioning manager who would be a key contact. Links to all PCC websites available here.
	National Probation Service (NPS)	Supervising those offenders who pose a 'high risk of harm' in the community. Other responsibilities include: • Providing assessments of prisoners and offenders to decide risk level. • Preparing pre-sentence reports for courts, to help them select the most appropriate sentence including in relation to the use of treatment • Through the gate resettlement planning for their cohort of prisoners prior to release from custody	To protect the public by the effective rehabilitation of high risk offenders, tackling the causes of offending, and enabling offenders to turn their lives around.	There are 6 regional divisions of the NPS.

Service	Organisation	Key responsibilities	Relevant aims and objectives	Key contact
		• Provide information on the treatment needs of offenders to local authority and health commissioners to inform provision of the treatment services vital for some community orders.		
	Community Rehabilitation Companies (CRCs)	Supervise offenders assessed as low to medium risk who are on license in the community, including those sentenced to less than 12 months in prison Responsible for providing 'through the gate' services for offenders ahead of release from prison.	To provide rehabilitative support and reduce reoffending among their clients. Contracts include a 'payment by results' element that depends on reducing reoffending.	A list of which CRC is responsible for resettlement services in each prison is available here.