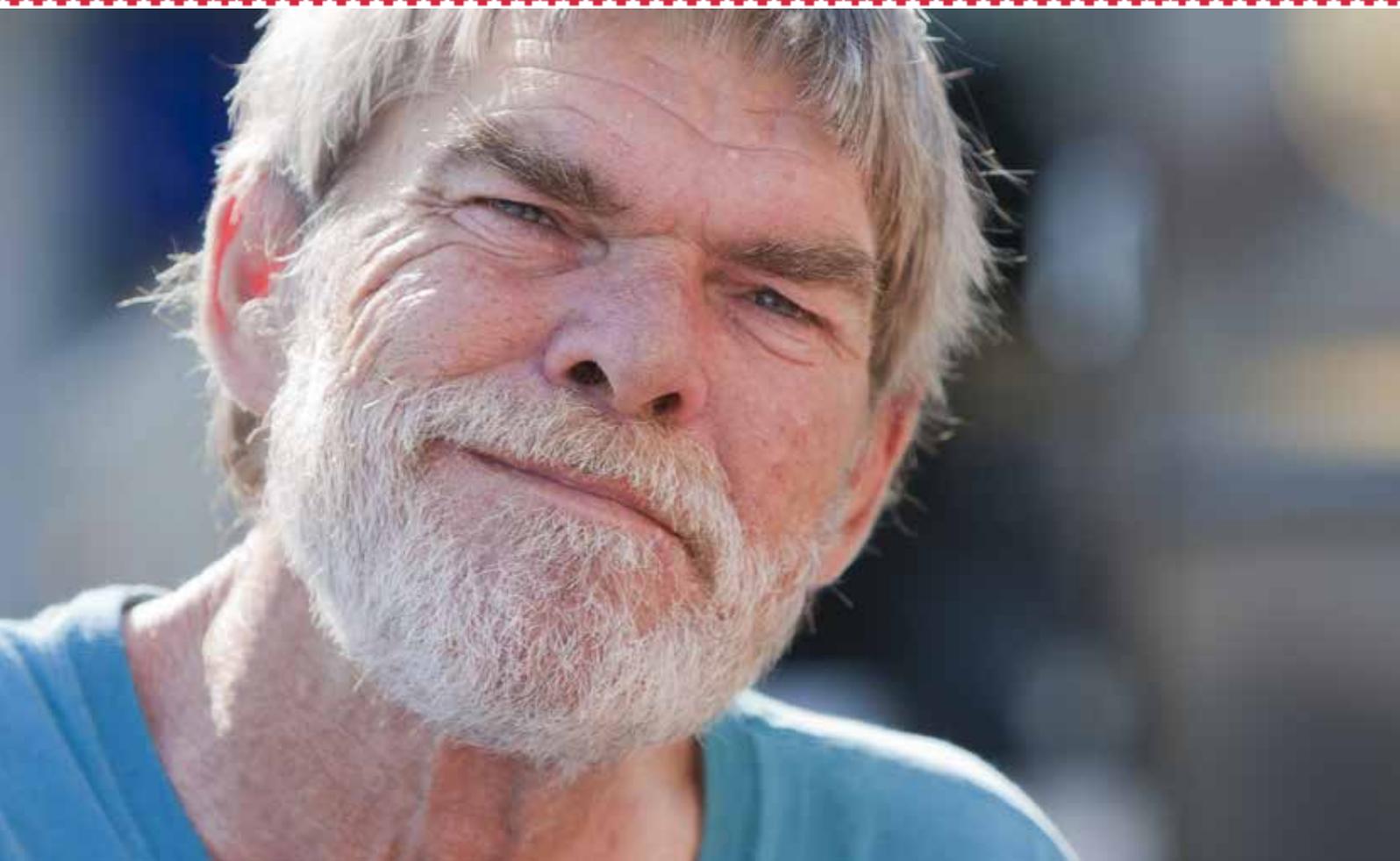
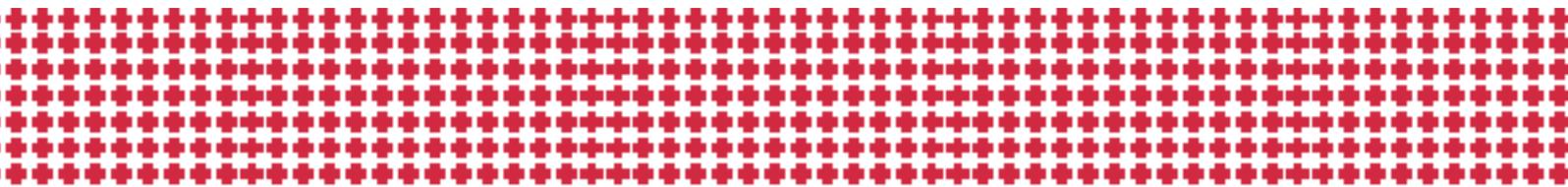


Homelessness and the Criminal Justice System

Guidance for Practitioners



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Contents

Introduction	3
Police Healthcare Provision	4
Offender Health Pathway	6
Mental Health and a Place of Safety	7
Courts	8
- Liaison and Diversion schemes	8
- Alternatives to Custody for People with Mental Health Problems	9
- Probation	10
Prison Healthcare	12
- Primary Healthcare	12
- Nurse Led Clinics	13
- Secondary Health Screening	13
- Mental Health	13
- Substance Misuse & Recovery Team	14
- Coalition Drug Strategy 2010	15
Release from Prison back to the Community	16
Prisoners and Tenancy	16
- Homeless Healthcare	16
Useful Organisations	17
References	18

Introduction

This guidance explains how the Healthcare issues of those engaging with criminal justice system are addressed and provides links to further information.

Recent research commissioned by Crisis and conducted by Sheffield Hallam University (2011) found that a fifth of homeless people have committed “imprisonable offences” to spend a night in the cells and more than a quarter of women rough sleepers took an “unwanted sexual partner” to escape their plight.

Crime can play a big part in rough sleepers’ lives. Nearly 30% admitted to committing a “minor crime such as shoplifting or anti-social behaviour” in the hope of being taken into custody for the night and a fifth of those questioned said they had avoided being given bail or committed “an imprisonable offence with the express purpose of receiving a custodial sentence as a means to resolving their housing problems”.

Further research by Niven and Stewart (2005) showed that 30% of people released from prison have nowhere to live and that homeless prior to custody had one-year reconviction of 79% compared with 47% for those in accommodation (MoJ, 2010).

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Police Health Care Provision

Police custody healthcare provision has traditionally operated through contractual relationships between Police forces and healthcare providers, with the purpose of meeting acute physical and mental healthcare needs of detainees and providing a forensic and legal medical service. Custody healthcare has tended to be located outside the NHS, subcontracted to independent sector providers who have most commonly employed Forensic Physicians and custody nurses. They often have liaison schemes in place with other health and social care services, and, increasingly, police forces are experimenting with nurse-led provision. (Healthcare of Detainees in Police Stations, BMA 2009). However, police custody healthcare is a key stage of the criminal justice pathway where NHS commissioned healthcare is not routinely available. This can impede an individual's access to NHS services when most needed. Furthermore, quality of police custody healthcare has not been subject to the same governance and performance measures as other NHS services (Bradley 2009), a concern raised in the Corston Report into women with particular vulnerabilities in the criminal justice system (Home Office 2007) and the 2007 Department of Health consultation on Developing an Offender Health and Social Care Strategy (DH 2007).

Police custody marks a crucial stage in the criminal justice pathway for identifying health and social need and providing access to appropriate treatment, care, diversion and referral. The Bradley Report highlighted that the majority of police custody detainees are subsequently found to have poor mental health, which is sometimes the underlying cause of their detention. Bradley emphasized that the police are therefore uniquely positioned to provide intervention and liaison with health and social care services. However, it was also stressed that this remains the least developed stage of the criminal justice health and social care pathway, in terms of engagement with health and social services, yet it provides the greatest opportunity to effect change through improving access to services for detainees, improving safety for individuals and the public, and providing valuable information to agencies at the later stages of the criminal justice system (Bradley 2009).

All police practices and responsibilities within custody suites fall within the stipulations and guidance of the Police and Criminal Evidence Act 1984 (PACE). This guides the police in matters relating to detention, treatment and questioning of suspects.

Under PACE, the police are required to provide a clinical response to those presenting with physical and mental health needs, fundamental to risk management and prevention of deaths in custody. If a detainee therefore requires medical attention, it is the responsibility of the custody officer to ensure that healthcare professionals have access to all available information relevant to the detainee's treatment and care (Home Office 2008; Bradley 2009). This applies whether or not the individual requests it and whether or not they have been treated elsewhere.

A health care professional (or an ambulance) will also be called if the detainee fails to respond to being roused, asked their name and other questions or commands.

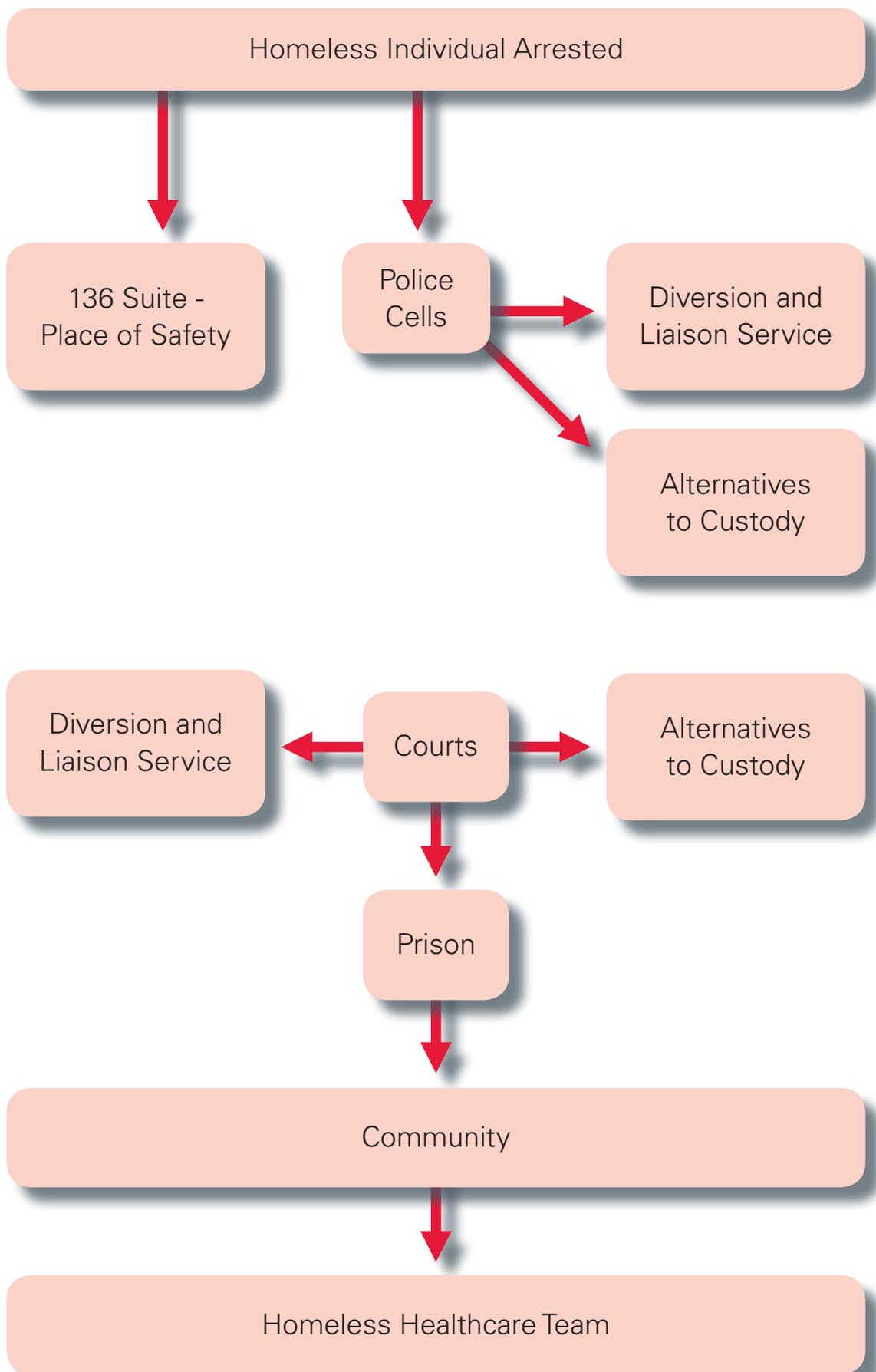
Some police stations will have access to a Mental Health and Learning Disability Liaison and Diversion scheme. It is hoped by 2014 that all custody suites will have some provision. Those that do not have access to a Liaison and Diversion service will contact either the local mental health services or the Emergency Duty Team (EDT) if there are concerns about someone's mental health.

In the case of juveniles under 17 years of age an 'appropriate adult' must be present during questioning and searching to make sure the accused understands what's happening. This might be their parent or guardian but is often provided by the local Youth Offender Team.

Mentally vulnerable adults should also have an 'appropriate adult' present but the reality is that often no one is available. The Local Authority will sometimes provide a mental health social worker or someone from the EDT, and some custody suites have access to a service provided by a voluntary sector organisation.

Appropriate adults are volunteers who play an important role in the custody environment by ensuring that the detained person whom they are assisting understands what is happening to them and why.

Offender Health Pathway



Mental Health and a Place of Safety

There are occasions when the police may act if they think that someone is in need of immediate care or control. They have the power to remove someone to a 'place of safety' for their own protection, or the protection of others.

Part of the Mental Health Act 1983 (section 136) details removing a mentally ill person from a public place to a place of safety. It details police powers and the rights of someone in this position.

The police, health authority and social services authority should agree a local policy for putting into practice section 136 of the act. For example, police officers should know who to contact at the local hospital and social services department.

A place of safety could be a hospital, a specialist unit or a police station. A police station should only be used in exceptional circumstances, such as a serious threat of violence or danger to people providing care or support. A person may be transferred from one place of safety to another before assessment. Taking someone to a place of safety will allow that person to be assessed by a doctor and interviewed by an approved mental health professional.

Approved mental health professionals are specially trained in both mental health and the law relating to it. They are appointed by local authorities to interview people and assess their well-being.

The maximum time someone can be detained at a place of safety is 72 hours (3 days). By then, any necessary arrangements for the person's treatment and care should have been made.

For more information about safer detention in custody read: Safer Detention & Handling of Persons in Custody 2012

- <http://www.homeoffice.gov.uk/publications/police/operational-policing/safer-detention-guidance-2012?view=Binary>

<http://www.ohrn.nhs.uk/resource/policy/PoliceCustodyHealthcare.pdf>

Courts

Liaison and Diversion schemes

"Diversion is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence."

- Bradley, 2009

As noted by Winstone and Pakes (2010), most diversion schemes now also play a wider role in offering support and liaison, both to offenders with mental health needs and to the agencies involved with them. Schemes are therefore often described as liaison and diversion schemes. The Sainsbury Centre for Mental Health (2009) regard liaison as a form of diversion, particularly in the outcome sense, i.e. steering people away from crime and towards better mental health.

This Toolkit has adopted the Bradley (2009) definition of diversion, as it usefully reflects the widest definition, acknowledging the varied core tasks of successful diversionary activity, namely the assessment and identification of health and social care needs at the earliest possible point, followed by decisions about suitable treatment, appropriately balanced by considerations of risk.

There are many different models of Liaison and Diversion Services across the country offering different levels of support, advice and diversion from custody. The role of the staff is not always an easy one, often relying on their local knowledge and relationships for better outcomes and access to services for the service users. The Offender Health Research Network are working closely with different service providers to look at potential future directions (November 2011). This work has developed some easy read care pathways for those service users suffering from Serious Mental Illness (Pathway 1) Common Mental Health Problems, (Pathway 2) Substance Misuse, (Pathway 3) Learning Disability (Pathway 4) and Personality Disorders, (Pathway 5).

Alternatives to Custody for People with Mental Health Problems

“Community sentences provide a robust alternative to short custodial sentences. Short prison sentences are often just long enough for a prisoner to lose their home, their job, their family, their benefits, their health and their mental health. Yet they are rarely long enough to establish robust resettlement plans, and they rarely achieve positive health, housing or employment outcomes”

- Khanom, Samele & Rutherford, 2009

Prisons have long been regarded by social reformers as serving as repositories for the mentally ill, disabled and the addicted as well as those who break the law (e.g. Howard, 1777). The size of the prison population in England and Wales has been a constant feature informing government policy over a number of decades, with changes in sentencing legislation and wider criminal justice initiatives combining to exert a powerful influence upon who our society locks up, and for how long. In particular, short prison sentences have been criticised as ineffective in terms of offering any useful contribution to rehabilitation or reducing criminal recidivism; re-offending rates for short prison sentences of less than 12 months increased from 58% in 2000 to 61% in 2008 (MoJ, 2010).

The homeless population more often than not fall into this category of prisoners, revolving door homeless offenders often only access Healthcare whilst in custody, and some will access Homeless Healthcare Teams where they are in existence. This means that the time spent in custody is often crucial in addressing any acute and chronic healthcare needs. There are pilot services being developed across the country, some of which offer Improving Access to Psychological Therapies as an Alternative to Custody, Gloucestershire and Warwickshire.

Acquired Brain injury research also concludes that a significant number of children and young people who enter the criminal justice system have suffered head trauma in their formative years.

Probation

In April 2005, the Community Order became the single, generic community sentence available to the magistracy and judiciary as an alternative to imprisonment. The Community Order was designed to bring under one umbrella order what previously would have been different orders, allowing sentences to be tailored to an individual's needs. The order allowed for the imposition of between one and all of 12 discrete requirements:

1. Supervision, by the probation service;
2. Compulsory unpaid constructive community work, up to a maximum of 300 hours;
3. Participation in specified activities such as improving basic skills (such as literacy) or making reparation to the people affected by the crime;
4. Prohibition from undertaking specific activities;
5. Undertaking accredited programmes, which aim to change offenders' behaviour;
6. Curfew, where an offender can be ordered to stay at a particular location for certain hours of the day;
7. Exclusion, where an offender can be excluded from specified areas;
8. Residence requirement, where an offender may be required to live in a specified place, such as an approved hostel;
9. Attendance centre. Offenders under the age of 25 may be required to attend a particular centre at a specified time for between 12 and 36 hours, over the course of their sentence;
10. Drug rehabilitation, which includes both testing and treatment, and can last for between six months and three years; again this can only be imposed with the consent of the offender;
11. Alcohol treatment. The offender must agree to treatment for at least six months;
12. Mental health treatment (MHTR), which can only be awarded with the consent of the offender.

A MHTR can last up to three years and currently needs to be conducted under the direction of an appropriate medical practitioner or a chartered psychologist and managed by an offender manager. Treatment can be as an in-patient (not high security), or provided in an out-patient/community setting. For a court to award a MHTR, they currently require evidence from a Section 12 (Mental Health Act 1983) medical practitioner that a person's mental condition is susceptible to treatment, yet not so severe as to warrant a hospital or guardianship order.² The court needs to be satisfied that the treatment required is available, and that the offender has expressed a willingness to comply.

Prison Healthcare

If you have concerns for the health needs of an offender on entry to the criminal justice system or if you need further information about someone on discharge – you may contact:

- ✚ Their probation officer if they have one
- ✚ The prison Healthcare Department
- ✚ The offender management unit of the Prison
- ✚ The Prison chaplain

As previously stated there is a wealth of evidence to show that many homeless people become revolving door prisoners, who often commit petty crime to get into custody. In February 2010 a local audit in Gloucestershire showed that 56% of the male population accessing the Homeless Healthcare Team, were revolving door, short term prisoners, some with as many as 4-5 sentences per year. Nationally a survey carried out by St Mungo's in 2010, shows that 48% of clients were ex-offenders or had been in prison.

In April 2006 the responsibility for the health of prisoners in England was transferred from prisons to primary care trusts (PCTs). In 2008 HM Prison Service and the Department of Health published a series of Prison Health Performance Indicators (Prison Health Performance Indicators, Gateway Ref: 8921, Department of Health, October 2007), which are updated on a yearly basis. The indicators were developed to measure the quality of prison health services and to help achieve the objective of NHS-equivalent standards:

“Prisoners should have the same range and quality of healthcare as the public receives from the NHS.” (The Future Organisation of Prison Health Care. Report by the Joint Prison Service and National Health Service Executive Working Group, HM Prison Service & NHS Executive 1999).

Prison is often the only place where offender's health is addressed at all. We therefore have to make the most of their time whilst in custody. Prison Healthcare is provided in different models across the different types of prison. Category A and B Prisons offer 24 hour healthcare facilities. Category C and D prisons offer Healthcare based on a GP Practice model, with GP's and nurses available during core hours (8am to 4pm). The last model of Healthcare services are sessional only with GP's and nursing staff visiting 2-3 times per week.

Primary Healthcare

The operation of Primary Care Services in prison is to provide a comprehensive range of Primary Care interventions for offenders in accordance with NICE guidelines. This involves assessment, treatment and through care for individuals identified as having a health concern.

The Primary Care team will seek to practice in a holistic manner with the overall aim of the service assisting individuals to develop and maintain an optimum level of functioning and quality of life within the prison environment.

The GP service is an opportunity for offenders to see a GP in a similar way to that they would access in the community. Applications for appointments are assessed by nursing staff and prisoners are triaged and directed to the appropriate service. All offenders who are received into prison will receive a general health, mental health and substance misuse assessment. Any physical health concerns picked up will be referred to the appropriate clinic waiting list or to the GP for an appointment within 24 hours.

The Primary care service model mirrors that available in the community. This has resulted in the removal of inpatient beds and released staff capacity to develop more meaningful daytime activities and more healthcare activity on the wings. Prisoners can self-refer to a number of services provided by the prison during custody including the stop smoking service. If a prisoner wishes to see a GP or attend a specific health care clinic they are required to complete a Healthcare Application Form. These are available on every wing and collected daily by the Wing nurse.

Nurse Led Clinics

There are lead nurses who are trained to manage a range of clinics in line with National Institute of Clinical Excellence guidance (NICE Guidelines). Referrals to outside agencies for example the local Acute Hospitals for specialist treatment are made as necessary. Lead nurse receives continuing professional development on a regular basis. Relevant equipment is available to support best practice and provide evidence based practice.

Secondary Health Screening

All offenders are given a secondary health screen (appendix 1) within 24 hours of arrival in Prison.

Mental Health

Mental ill health is extremely common in prisons. Previous research has provided a plethora of statistics demonstrating the extent of mental illness in prisons including:

- ✦ 72% of male & 70% of female sentenced prisoners suffer from two or more mental health disorders
- ✦ One in five prisoners has four of the five major mental health disorders.
- ✦ A significant number of prisoners suffer from a psychotic disorder. 7% of male and 14% of female sentenced prisoners have a psychotic disorder; 14 and 23 times the level in the general population.
- ✦ 10% of men and 30% of women have had previous psychiatric admission before they entered prison.
- ✦ The proportion of people in prison who have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system has been estimated at 20 to 30%.
- ✦ 23% of those under 18 years of age in prison have an IQ of less than 70.
- ✦ Estimated that 50%-70% of prisoners have some sort of personality disorder

A number of national policy documents and guidance that relate specifically to the delivery of mental health services in general and within the prison service have been taken into account:

- ✦ Improving Health, Supporting Justice, (2009)
- ✦ The South West Offender health and Well-being Delivery Plan.
- ✦ Changing the Outlook (2001)
- ✦ The Offender Mental Health Care Pathway (2005)
- ✦ Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the 'Mental Health Act (1983)' (2005)
- ✦ From Segregation to Inclusion: Commissioning Guidance on Day Services for People with Mental Health Problems (2006)
- ✦ Troubled Inside: Responding to the Mental Health Needs of Men in Prison (2005)
- ✦ Too Little Too Late (2009) Prison Reform trust.
- ✦ Prison Health Performance Quality Indicators (2012- 2013)
- ✦ The Bradley Report (2009)

Mental health care will be delivered through a single mental health team that encompasses all the skills required to deliver the service specification. This involves assessment, treatment and through care for individuals identified as having a mental health issue. The Mental Health team will seek to practice in a holistic manner with the overall aim of the service assisting individuals to develop and maintain an optimum level of functioning and quality of life within the prison environment

The team will deliver the 'Stepped Care model'; this approach builds a menu of services from which a person can choose the intervention most suitable to them. Stepped care refers to a model in which the simplest and least intrusive interventions are offered at first presentation only stepping up to more complex interventions when necessary.

Although careful risk assessment is required, such approaches can theoretically reduce demand on more specialist services. The approach also offers a more graded discharge route out of specialist services

Substance Misuse & Recovery Team

In response to concerns raised in many reports regarding lack of equality in treatment and the risk of post-release overdose, Integrated Drug Treatment Services were introduced across the Prison Service from 2006/07.

Drug services have developed rapidly and policies have evolved with regard to clinical management especially opiate substitute prescribing and detoxification. Clinical guidelines issued by the National Treatment Agency and NICE are comprehensive and thorough with regard to management of drug misusers on the Prison system.

The move within all drug services towards emphasis on recovery has stimulated further advances within Prison drug services and helped move towards a holistic model of treatment that draws together treatment interventions aimed at addressing all aspects of health and to support referral into further treatment options following release from prison. A range of interventions are available within the Prison system dependent upon length of sentence and drug team. Staff liaise with Offender Managers to coordinate evidence based, effective treatment planning.

The aim of Prison Substance Misuse Services is to provide a seamless, comprehensive and responsive service for offenders with a drug and/or alcohol problem (regardless of dependence) that is recovery focussed and follows NTA & NICE guidelines. This involves clinical assessment, appropriate prescribing, and psychosocial interventions to include through care & follow up for individuals identified as having a substance misuse issue. The Substance Misuse team will seek to work with and empower individuals to address their substance misuse issues using a multidisciplinary holistic approach to ultimately become drug/alcohol free and make positive changes for themselves, their families and to their contribution in society.

Coalition Drug Strategy 2010

"Prison may not always be the best place for individuals to overcome their dependence and offending behaviour. We are continuing to support areas in delivering the Drug Interventions Programme (DIP), and want to ensure that offenders are encouraged to seek treatment and recovery at every opportunity in their contact with the criminal justice system (CJS). In addition, we will encourage those dependent on drugs or alcohol into recovery-focused services in the community by:

- ✚ Developing/evaluating alternative forms of treatment-based accommodation in the community;
- ✚ Making liaison and diversion services available in police custody suites and at courts by 2014; and
- ✚ Diverting vulnerable young people away from the youth justice system where appropriate.

A number of national policy documents and guidance that relate specifically to the delivery of drug and alcohol services in general and within the prison service have been taken into account.

- ✚ Drug Strategy (2010)
- ✚ Drug Misuse & Dependence, UK guidelines on clinical management (2007)
- ✚ Clinical Management of Drug Dependence in the Adult Prison Setting (2006)

Release from Prison back to the Community

Many prisons run a pre-release clinic whereby the Healthcare staff attend a weekly or two weekly clinics for offenders who are due to be released in the following 6 weeks. The staff will ensure that any follow up appointments are made and given to the offender. They will arrange a GP if needed or give the offender names and addresses of local GP's where they can register on release, or they will refer them to the Homeless Healthcare Teams where available. There have been some good examples of partnership working with Prisons and Homeless Healthcare Teams, including a role that covered both areas. (Nursing Times 7th April 2011). There are also other roles within the Offender Health which are seen as good examples of partner working, Clinical Service Manager for Offender Health. (Independent Nurse 3rd September 2012)

Prisoners and Tenancy

Most prisons provide specialist housing advisers to help with housing problems. To improve the chances of keeping their home, prisoners should arrange to meet with an advisor as soon as possible. In addition, prisoners are advised to contact their landlord or mortgage company to let them know of their situation, and have any important paperwork posted to the prison. If prisoners were receiving Housing Benefit or Council Tax Benefit before, it is important for them to make contact informing the council of their change in circumstance.

Support for maintaining a prisoner's home depends on whether they rent or are an owner-occupier. For more information on how to maintain occupancy while away can be found at <http://www.citizensadvice.org.uk/>.

If prisoners were unable to keep their home, they should seek counsel from a specialist housing adviser upon release. In some circumstances the council may have to find accommodation, depending on whether they fall into the category of priority need (i.e., disabled individuals; those with health, drug or alcohol problems; those living with dependents prior to prison). If the council cannot provide help with accommodation, offenders may be able to find accommodation in a hostel. Private rental may be possible as well, though most landlords require deposit and payment in advance.

Useful Organisations

Citizens Advice Bureaux

Citizens Advice Bureaux give free, confidential, impartial and independent advice to help you solve any sort of problem.

Nacro

Nacro is a specialist organisation which provides services for ex-prisoners, including housing, resettlement and education/training. You can contact Nacro on: 0800 0181 259 (freephone) or visit their website at: www.nacro.org.uk.

Shelter

Shelter is a specialist organisation that helps people with housing problems. Phone the Shelter helpline on 0808 800 4444 to find out your nearest Shelter or visit <http://www.shelter.org.uk/>

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