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Prison health in Europe: Missions, roles and responsibilities of international organizations.
Council of Europe, Strasbourg, France 27 May 2014

Public Health England: Our Mission, Roles & Responsibilities in Health & Justice

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PHE Mission Statement on Health & Justice

- Public Health England (PHE) will work **in partnership** with **health & social care commissioners , service providers, academic & third sector organisations and international partners** to **identify and meet** the **health & social care needs of people in prisons and other prescribed detention settings, as well as those in contact with the criminal justice system (CJS) in the community.** .
- PHE will aim to **reduce health inequalities**, **support people in living healthier lives**, and **ensure the continuity of care in the community**.

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Role of PHE in Health & Justice:

- PHE will **gather and provide evidence and intelligence** to inform and support the work of local and national commissioners and service providers;
- PHE will **provide expertise at local, national & international level (in our role as UK CC for WHO HIPP)** on a broad range of health protection, health promotion and disease prevention activities working in close partnership with local commissioners and service providers.
- PHE will support partners, including commissioners and providers of health and social care, in the **development of care pathways** which account for the movement of people **around the detention estate** and **between prescribed detention settings and the community.**

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PHE Resources for Health & Justice:

- PHE also has a **dedicated resource** to support work on understanding and managing the health needs of people in contact with the criminal justice system.
- The **national team** sits within the **Health & Wellbeing Directorate**;
- **Ten Health & Justice Public Health Specialists** are based in **Public Health England Centres**, working in the Operations Directorate, and 'man-marking' the ten NHS England AT Health & Justice Lead Commissioners;
- These with the national team form the **Health & Justice Network**;
- These resources within both NHSE and PHE at national and local level allow for **effective horizontal and vertical integration within organisations and between organisations.**

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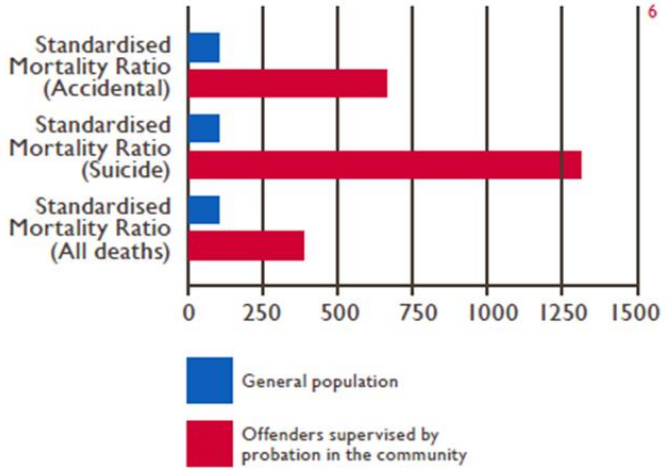
Higher Mortality Rates among people in contact with CJS



- Data on **all cause mortality** among current and or ex-prisoners is difficult to identify and collect;
- However, in jurisdictions where such collections are possible, **dramatic differences** are evident between current or former prisoners and general population in relation to **all cause mortality** as well as **accidental death** and **suicide**.
  - Data from the UK is shown as example.

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‘Underserved’ NOT ‘hard to reach’

- People in PPDs often described as belonging to ‘hard-to-reach’ populations;
- This is NOT true- more accurately described as ‘under-served’ both in prisons and in the community;
- ‘Hard-to-reach’ implies some active withdrawal by population whereas ‘underserved’ describes situation where services fail to meet needs of population in appropriate ways.
- Need to stop blaming the patient for being ‘difficult’ and recognise instead difficult circumstances (personal, social and cultural) in which patient often lives as being a barrier to their accessing ‘conventionally delivered services’.

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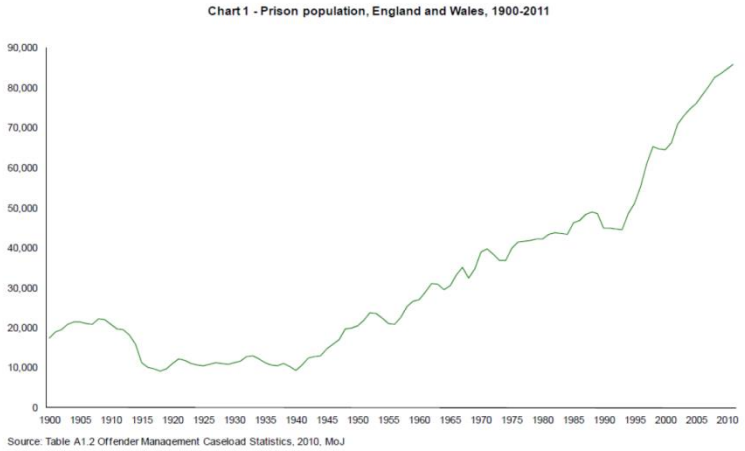
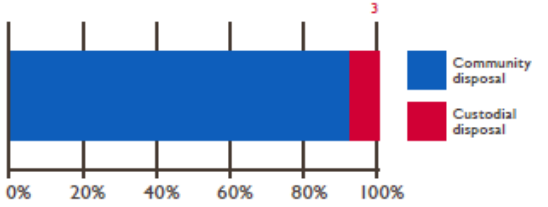
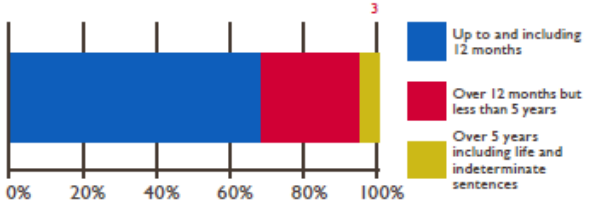
Population Factors



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



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



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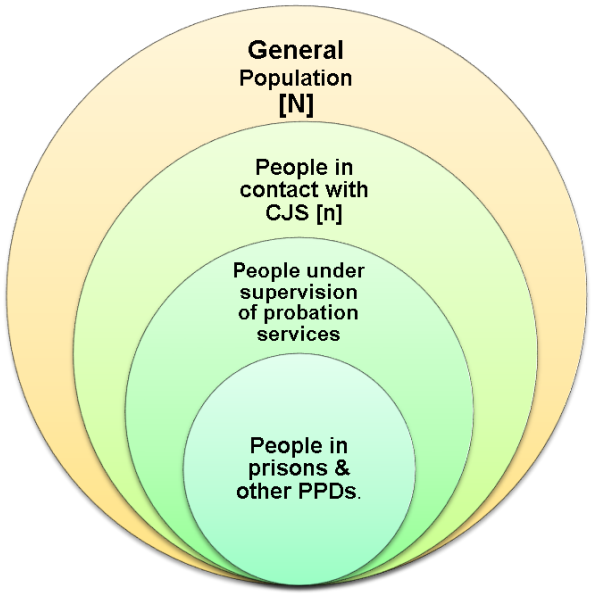
‘Community Dividend’ for public health interventions in prison populations



- **Underserved populations** passing through prison estate ~160,000 per year;
- Often belong to **wider social groups and networks** contributing significantly to **health inequalities generally;**
- Delivering **health interventions in prisons** not only benefits prisoners- ‘**community dividend**’ in addressing issues in underserved populations generally.

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PHE Vision for Health & Justice internationally

- Recognise prison is a '**setting'** where populations with high level of health needs are collected for variable periods of time;
  - **Interventions** can be delivered in this setting to address **immediate health needs** and **longer term conditions**;
- But prison is only a 'setting' on a complex '**care pathway**' through **both health and justice systems;**
  - **Effectiveness** of prison-based interventions will be **minimised** if care pathways do not **extend beyond the prison walls;**
- Need to think about both **'upstream'** and **'downstream' interventions** in both **health and criminal justice systems** to realise **health dividend** for under-served populations and **reduce offending/re-offending behaviours**;
- Need **international collaboration and cooperation** to **gather data** and '**upscale'** interventions **to detect impacts, positive and negative**.

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Public Health Model for Health & Justice:

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The role of the UK CC WHO HIPP

- The **UK Collaborating Centre**, working as part of a multi-disciplinary specialist team within PHE, will oversee, coordinate and deliver high quality professional input, technical support and advice to the **WHO Regional Office in Copenhagen and European partners** on a range of health and social care issues associated with Health and Justice**, including the health & wellbeing of people in prisons & other prescribed places of detention (PPDs)** as well as those in **contact with the criminal justice system (CJS) in the community;**

- The **UK Collaborating Centre (UK CC)** for the Health in Prisons Programme provides direct support to WHO HIPP to deliver on its mission.
  - The UK CC was hosted initially by the **Department of Health (DH) in England** which contracted it to the University of Central Lancashire (UCLan).
  - In **April 2013**, responsibility for the UK CC passed on to **Public Health England** (PHE) with agreement to August 2017.
  - The function of the UK CC continued with UCLan **until April 1, 2014** when it was brought 'in-house' to **PHE's Health & Justice Team**, based in London & Reading, Berkshire.

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Key achievements of UK CC under PHE leadership

International Leadership

- **Joint PHE/WHO two day international conference in London in October 2013**, including launch of WHO policy document '**Good Governance for Prison Health in the 21st Century';**
- Foundation with European partners of **'Health Without Barriers- The European Federation for Prison Medicine'**- fringe meeting of London conference and constitution agreed at meeting in Turin, Italy last week;
- Keynote speech on Health & Justice at **American Public Health Association conference, Boston, November 2013;**
- **Foundation of Five Nations Health & Justice Collaboration** with England, Northern Ireland, the Republic of Ireland, Scotland and Wales with first meeting in London, February 2014 and next meeting in Dublin, June 2014;

National Leadership

- **Integration of WHO role into wider specialist work of PHE Health & Justice team**, including participation in new Health & Justice national network;
- **Uplift of funding by PHE** for work by 50% for year 2014-15 (£80K -£120K);
- Publication of **Balancing Act**, October 2013;
- **Chapter on Health & Justice** in **CMO report**, April 2014.
- **Joint PHE/Irish Prison Service/WHO meeting** in **Ireland** being planned for October 2014.
- Creation of **joint PHE/WHO Public Health post as part of re-design of UK CC structure within PHE.**
  - **Interim Public Health Specialist (currently recruiting);**
  - **New Public Health consultant role being recruited to this summer.**

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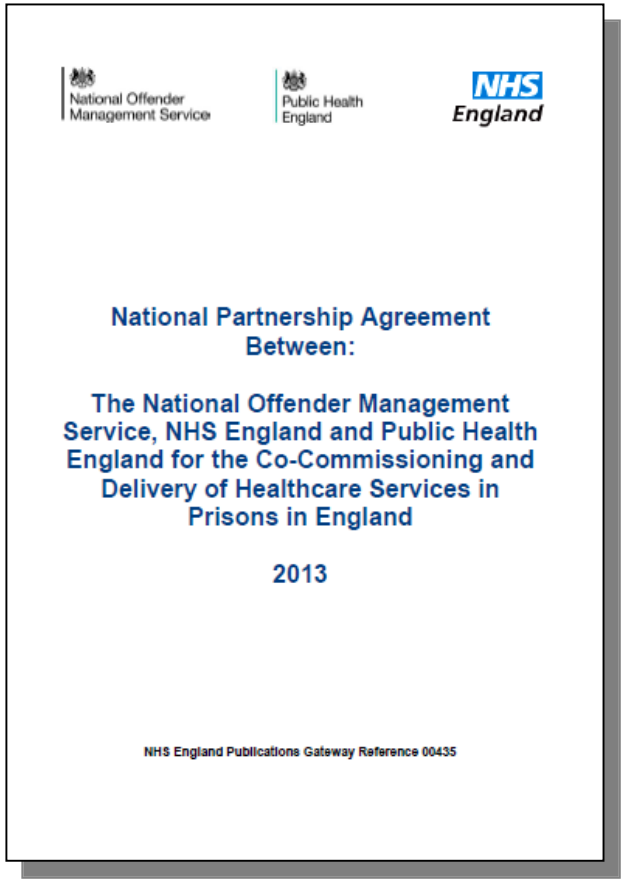
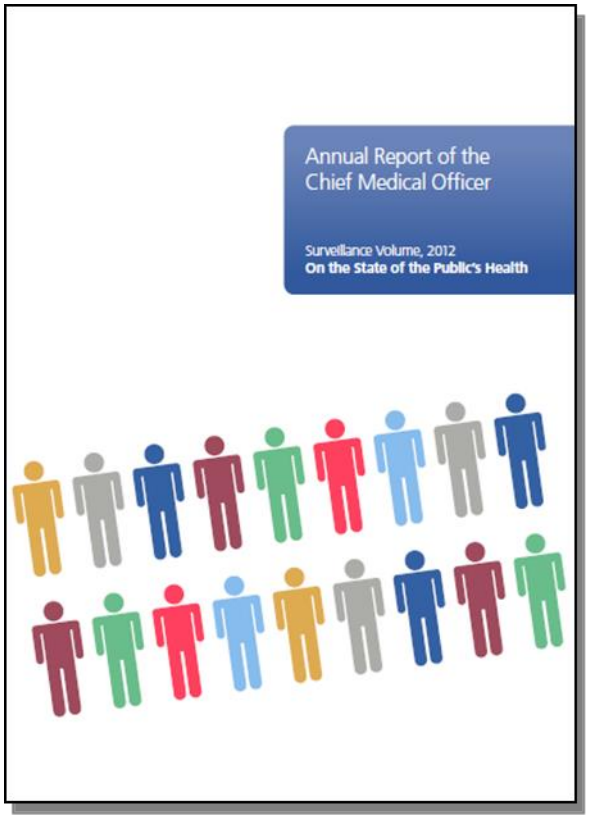
Key publications of UK CC/PHE H+J 2013-14





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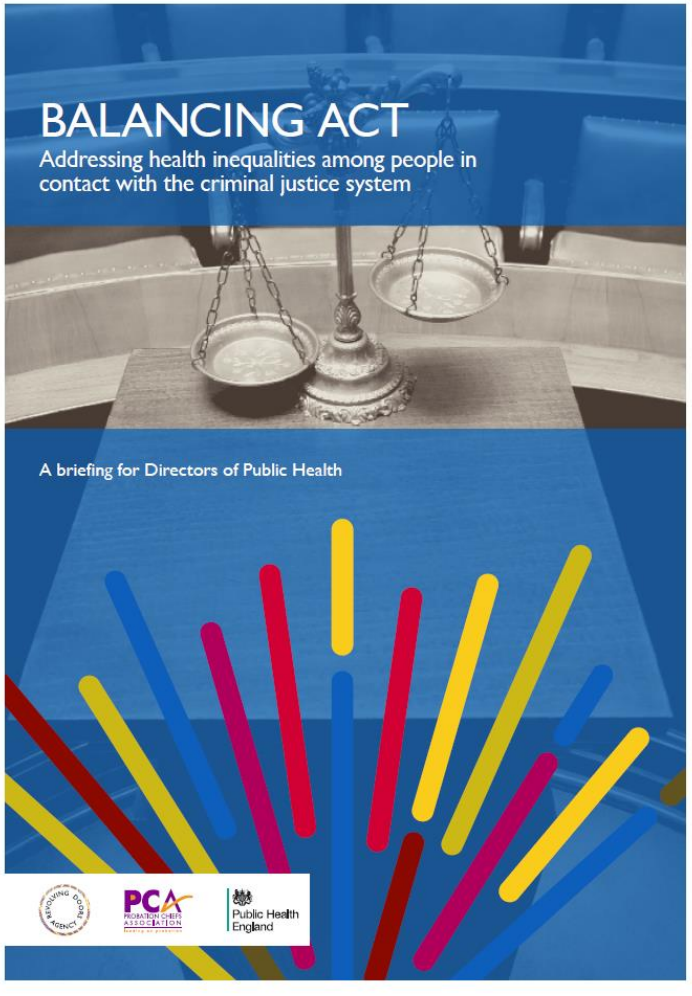
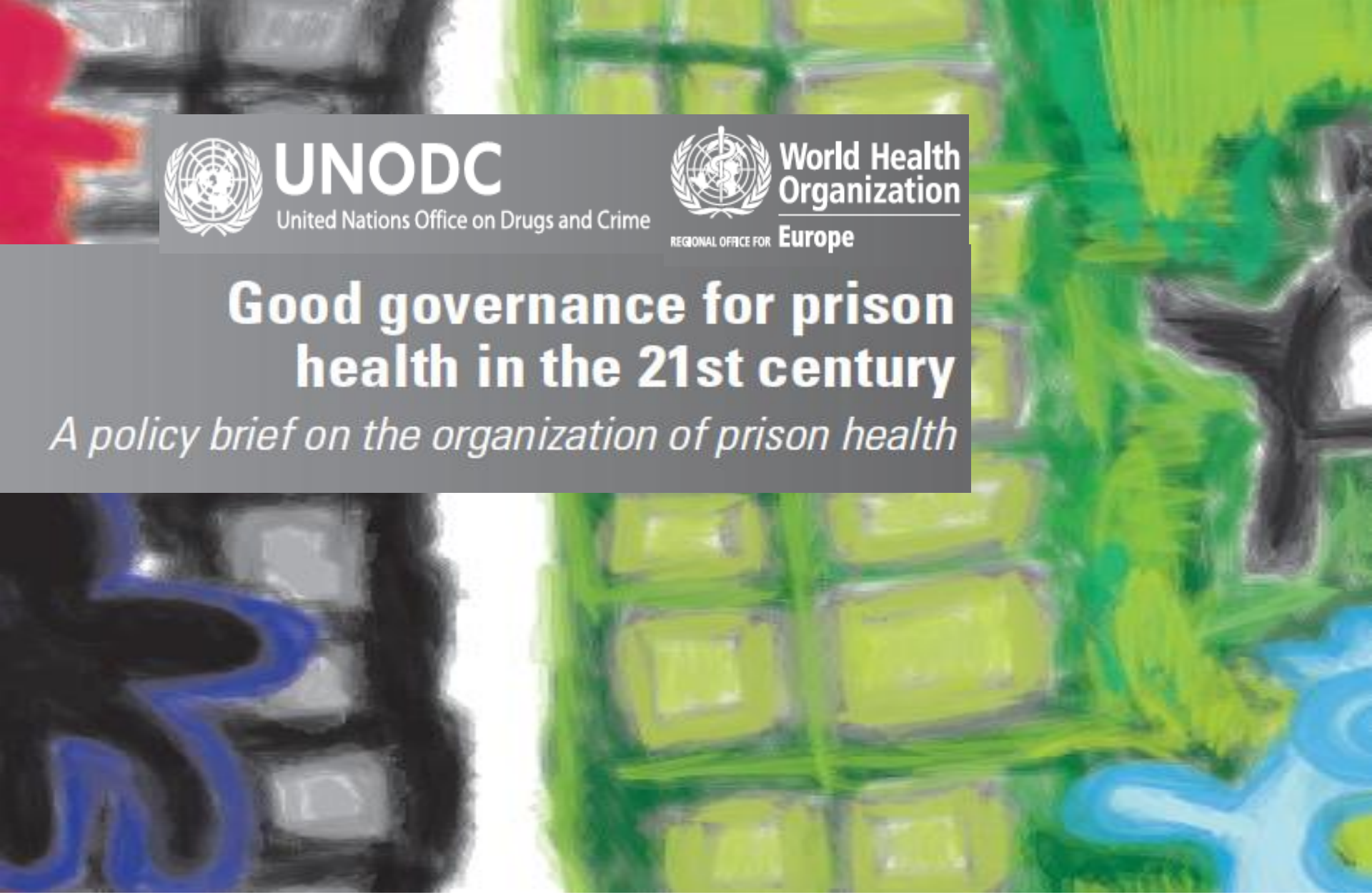
Balancing Act

- A briefing for Directors of Public Health published Oct 2013 which suggests positive actions and approaches DsPH could use to tackle the health inequalities of people in contact with the criminal justice system residing in their local community;





UNODC
United Nations Office on Drugs and Crime

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REGIONAL OFFICE FOR Europe

Good governance for prison health in the 21st century

A policy brief on the organization of prison health

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Our principles:

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- **Equivalence:** People in prison and other places of detention are entitled to care **equivalent** to that available to people in the wider community;
- **Evidence-based care:** Care commissioned and provided according to needs, informed by rigorous health needs assessment approach, including collection and interpretation of data, and must be evidence-based;
- **Patient-focussed:** People delivering care to people in prisons and other places of detention are healthcare staff whose primary loyalty is to the health and well-being of their patients.
- **Quality:** Healthcare staff should be appropriately trained and accredited, participate in continuing professional development programmes, and work within a clear clinical governance structure.
- **Patient voices:** Prisoners and detainees should know their rights, should have their voices heard in designing and delivering healthcare services, and should know how to complain if unhappy with the level of service they receive.
- **Partnership:** Working in partnership is essential- we advocate ‘co-production’ with partner organisations.
- **Continuity of Care**: Our role does not stop at the prison gate- we must support care pathways through the gate.
- **Wider than prison impact**: Prison health is everyone’s business- addressing needs of ‘hard-to-reach’ groups in prison has a ‘ripple effect’ into the wider community;
- **Health and Justice:** Health and healthcare is part of the problem and part of the solution- no health without justice, no justice without health

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Conclusions:

- Public health challenges associated with detention settings are **significant and increasing;**
- Prisons & other places of detention represent **an opportunity to address health inequalities** in these settings specifically and society generally.
- Challenge to ensure that work commenced in prisons and other detention settings is appropriately **continued on return to the community-** avoid 'cliff edge';
- **PHE** propose a new model of working in Health & Justice, where prisons are an important setting on a complex care pathway recognising that most 'offenders' return to their communities;
- Health and Justice organisations internationally must work in **'co-production**' mode to ensure effective design & delivery of services in prisons and beyond the prison walls.

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