Equality Impact Assessment of Improving Health, Supporting Justice

October 2009, Gateway Reference 12632

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Undertaken by: Health & Social Care in Criminal Justice Programme, (Department of Health South East) in partnership with Offender Health (Department of Health)

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Acknowledgments

The project team would like to pay a particular tribute to the equality and diversity leads within the prison estate who supported the consultation process, often at short notice and within strict limitations. The assessment process highlighted the pivotal role these leads play in supporting offenders with specific needs who would otherwise be further excluded.

Additionally, the project team of HSCCJP Department of Health South East would like to acknowledge the support of:

Beverley Thompson, National Offender Management Service

Governors and Equality Governor Leads HM Prisons, National

Offender Management Service

Jane Forsyth, DH Offender Health

Community Groups representing ex-offenders

Offenders who took part in focus groups and one to one interviews

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Context

Improving Health, Supporting Justice: A National Delivery Plan

In April 2009, the government published its response to Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (CJS). Within it, the government accepted the direction of travel set out by Lord Bradley, and committed to developing a new strategic delivery plan for health and criminal justice, incorporating the full response to the report's recommendations.

Published in November 2009, *Improving Health, Supporting Justice: A National Delivery Plan (*henceforth referred to as 'the delivery plan') draws heavily on feedback received from stakeholders during the earlier formal consultation of the same name[1] (see section on Consultation) as well as the recommendations set out in Lord Bradley's report. It was developed under the auspices of a cross-departmental Programme Board[2], set up in response to a specific recommendation by Lord Bradley, and has also taken into account other recent important publications, such as Baroness Corston's review of provision for vulnerable women who come into contact with the CJS, the government's plan that followed and a strategic analysis by the Prime Minister's Strategy Unit on mental health and offending. In addition, the work has been informed by a wide range of reports and research, particularly by third sector organisations, over recent years which have aimed to quantify the problems and propose specific solutions. This forms the first real opportunity to pull all this work together in one place to form a cohesive, strategic approach.

The delivery plan examines how services can work to ensure that offenders receive appropriate, sensitive and effective care throughout their transitions and during the criminal justice pathway.

What do we mean by equality and diversity?

Equality is essentially about **creating a fairer society** where everyone can participate and has the opportunity to fulfil their potential. It is backed by legislation designed to address unfair discrimination (past, present or potential) that is based on membership of a particular group. In some circumstances, positive action is encouraged to address discrimination. It is often summarised in terms of

- Equal access
- Equal treatment
- Equal shares
- Equal outcomes

[1] Improving Health, Supporting Justice, A Consultation
[2] Reference to Annex 3, Membership of Health and Criminal Justice Programme Board

Diversity is about the **recognition and valuing of difference** in its broadest sense, and creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual. The term describes the range of visible and non-visible differences that exist between people. Managing diversity harnesses these differences to create a productive environment in which everybody feels valued, where talents are fully utilised and in which organisational goals are met[3].

Equality and diversity are not interchangeable but are interdependent. There is no equality of opportunity if difference is not recognised and valued.

The significance of equality in offender health policy

The issue of equality - whether through ensuring equity of access to services, or addressing health inequalities - has long been at the heart of offender health policy. Evidence of the substantial over-representation of people from socially excluded sections of the community in the offender population is now well documented. Whether in prison or under community supervision, offenders display many times the average incidence of factors such as mental health problems, homelessness and poor educational achievement. Many offenders, but especially those in prison, suffer from multiple, inter-related disadvantages, often linked to substance misuse. Frequently, these have their roots in childhood deprivation or negative experience of early adolescence.

We also know that people within the criminal justice system often experience significant problems in gaining access to adequate health and social care services and often have low expectations about their quality of life. Offender health policy works to ensure that health and social care professionals can contribute to improving these aspirations through their interactions with people in terms of time, relationships and sharing information.

Additionally, research has shown that offenders generally do not access the health services they need outside of prison. The CJS therefore offers a health setting which allows access to the otherwise 'hard to reach' sections of the population, and a prime opportunity to address health inequalities, through general engagement with NHS health services and specific health promotion, treatment and prevention interventions. For the many people who have led chaotic lifestyles prior to contact with the CJS, it is sometimes their best opportunity for an ordered approach to assessing and addressing health and well-being.

Improving access to services before contact with, and at all points of the CJS system (in the community, on arrest, at court, prison or community sentence) can be expected to lead to an increase in the chances of successful resettlement, the reduction of further offending and a more efficient and just system.

[3] Kandola and Fullerton 1998

Why do we need an Equality Impact Assessment?

Legal Requirements

The statutory duties under the Race Relations (Amendment) Act, the Disability Discrimination Act and the Gender Act require public bodies to undertake equality impact assessments (EIA) on their functions and policies to assess adverse impact on the grounds of race, gender and disability. This has also been extended to cover European regulation duties for age, sexual orientation, religion or belief. As public organisations have moved towards the development of single equality schemes, in anticipation of the Equality Act, all six strands are now integral to meeting the requirements of an equality impact assessment. Further impetus is also provided by the Human Rights Act and requires specialist legal advice to assess adverse impact on those groups and individuals subject to and affected by the policy. It should also be noted that transgender issues are a separate component of the Gender Discrimination Act and therefore we may refer to the seven strands of equality plus one (Human Rights) as a matter of principle within this document to ensure equity of purpose. The Equality and Human Rights Commission (EHRC) states of its own process:

"As part of any effective policy development process, it is important to consider any potential risks to those who will be affected by the policy's aims or its implementation".

The role of equality impact assessments in making policy

The EHRC provides a valuable definition stating that: *"It is necessary that to undertake EIA's to ensure that our own policies, practices and functions* (hereafter referred to as 'policies') *do not adversely affect or discriminate against any equality group. EIA's not only help us to consider any potential risk on different groups, but also offer an opportunity to consider how the policy may help to further develop equality. They are a major part of a wider approach to policy-making, where the principals of monitoring and involvement lead to policies that are user-focused and based on sound evidence*"[4].

What does an equality impact assessment involve?

There are two stages to an EIA. Firstly, an initial screening process must be undertaken to decide whether the policy has the potential for adverse impact on the promotion of equality. It is rare that a policy does not have an adverse impact and therefore the project team took the view that all policies should move towards the second stage of a full EIA. For the policy author, it is important to ensure that any policy under construction does not have the potential to cause unlawful indirect or direct discrimination, as well as to ensure no opportunity to promote equality has been omitted. It is also

[4] See: www.equalityhumanrights.com/our-job/our-equality-impact-assessments

important to consider the need to promote equality of opportunity and good relations between different groups and sections of the community. If that policy does not meet these standards, it has to be amended accordingly to mitigate or eliminate the potential for discrimination and promotion of equality. This is a positive duty imposed upon public authorities and should be seen as a proactive measure rather than a reactive process, once the potential for discrimination has been highlighted.

The key elements that are essential in an EIA are:

- Assessing adverse impact
- Collating data and, if required, commissioning new data
- Consultation and Involvement with groups affected by the policy
- Monitoring arrangements
- Publishing the process and EIA

Taking this forward

The EIA of the delivery plan should be seen as an initial, overarching, assessment. Each deliverable specified with the delivery plan will in turn be subject to a full equality impact screening and assessment.

The findings from this EIA have been fed into the policy development stage and should be recognised as key areas for development to ensure equality of access for all. One of the key objectives of the delivery plan promotes equity of access, and this should be the primary vehicle for addressing these findings. This delivery plan forms a real opportunity to mitigate any potential for discrimination and systematic bias in health and social care delivery for offenders within the context of the seven strands of equality.

It will be essential to ensure equality issues are mainstreamed within the core of developing policy around health and criminal justice, and this should be achieved incrementally and with additional support from external and internal equality and human rights specialists. Regular reviews and monitoring will be undertaken by senior managers and the National Advisory Group. This EIA firmly advocates a systematic and robust equality impact assessment methodology that has been tested and refined as part of this work and will now extend into the core national and regional activities of Offender Health, in partnership with our key stakeholders and other Government Departments.

It outlines an Equality Action Plan (See chapter on Next Steps), which provides a framework upon which to build and ensure the principles, ethos and values of equality and human rights. Now captured as the building bocks of improvement in health and criminal justice policy, we can better meet the individualised and distinct needs of all groups within the wider offender population.

Methodology

The Health and Social Care in Criminal Justice Programme (HSCCJP) of the DH South East were commissioned by DH Offender Health to undertake the EIA of the delivery plan within the context of the statutory duties outlined above and in recognition of the importance of building quality and diversity issues into Departmental policy. A limited consultation process was also undertaken for Offender Health's Children and Young People programme in support of the offender health and social care strategy for children and young people, a sister document to the delivery plan. This strategy will be subject to a separate equality impact assessment and is not referenced within this document.

The resulting EIA assesses the potential for adverse impact from the strategy on the grounds of:

- Race
- Gender
- Gender Reassignment
- Disability
- Sexual Orientation
- Religion or Belief
- Age

The HSCCJP project team refer to this process as the seven strands plus one, the remaining element being the Human Rights Act.

The project team consisted of an experienced group of individuals with substantial knowledge of the equality and diversity agenda, having worked locally, nationally and regionally on promoting equality within the NHS and public services in both an operational and strategic capacity. They have a combined experience of twenty years. Although part of Offender Health's regional presence, for the purposes of this commission the team viewed themselves to be independent of the DH. This allowed them to maintain objectivity and provide a robust framework to ensure any negative impact on specifically socially excluded groups was mitigated or eliminated. The team provided advice to policy leads in the DH on drafts of the delivery plan to ensure equality would be embedded not only in the spirit of the document, but also in its practical implementation both regionally and nationally.

The HSCCJP team also provided guidance where necessary to ensure policy leads had a greater understanding of the needs of the diverse group of offenders across the offender health and social care pathway. Although there are, of course, limitations in how this advice is received and acted upon, all guidance has been reflected in the ensuing action plan (see section on Next Steps).

The overall intention was to undertake a process that had real impact, contained real views and experiences of offenders and ex offenders, and led to change via greater reflection of specific needs within policy making.

The following section sets out the detail of the approach to undertaking the EIA of the delivery plan. The project team cannot guarantee a totally rigorous methodology given the special circumstances posed by the prison environment in which the consultation was largely conducted. Learning from this process will be fed into future activity.

Engaging our stakeholders

In the initial stages of the project, contact was made with the nominated diversity leads in each custodial establishment (or the equivalent lead person in the relevant secure training centre or secure children's home) to inform them of the work and gain their support. A letter outlining the process and the rationale for the work was also issued, supported with an explanation by the Head of Race and Equality at the National Offender Management Service (NOMS), which incorporates the Prison Service.

Literature Review

A review of available literature was commissioned by HSCCJP South East and undertaken by the Public Health Research Unit based in Oxford[5]. This was published in March 2008 and aimed to:

- Present a broad demographic picture of each of the seven strands of equality and diversity in terms of population numbers and characteristics;
- Summarise the contact with health services that this group are known to, or may, have;
- Provide a baseline summary of what is known about each group's interaction with the CJS in terms of contacts with the police, courts, prisons and probation service;
- Identify areas where data does not appear to be readily available;
- Identify sources in the wider literature that provide an indication of contacts, or incidence/prevalence, where no data is routinely recorded by the health or justice systems.

[5] Department of Health Website - www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097136

Consultation

Improving Health, Supporting Justice

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

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

In addition, the document was sent directly to 140 key stakeholder groups, and 80 copies of the document were issued to each of the ten Health and Social Care in Criminal Justice leads providing regional support across England, for distribution to additional regional stakeholders. By the end of the consultation period, 2,100 paper copies of the consultation document had been distributed. It was also available to download from the DH website although no information is available for the activity on the site.

The consultation formally ended on 04 March 2008, with the final return received on 28 March. It sought views on the proposed strategic direction for health and criminal justice policy in accordance with the Cabinet Office's Code of Practice on Consultation.

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

The findings from this consultation have informed the development of the delivery plan. A full independent evaluation of the consultation is available to download from the DH website[6]. This contains a full list of those consulted.

[6] **Independent evaluation report of Improving Health, Supporting Justice: A Consultation Document**
A strategy for improving health and social care services for people subject to the criminal justice system
Charlotte Rennie and Amanda Roberts, Offender Health Research Network, July 2008.
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_087276.pdf

Bradley Review

In December 2007, the Rt. Hon Jack Straw MP, Secretary of State for Justice and Lord Chancellor announced a review, reporting jointly to the DH and the MoJ, to look at how more offenders with severe mental health problems can be diverted away from prison and into more appropriate facilities.

Lord Bradley's report was formally published on 30 April 2009 and was the product of a full consultation. Regional stakeholder events, attracting over 500 delegates, were hosted to ensure that the views and experiences of local staff and stakeholders informed and shaped the final recommendations made by Lord Bradley to government about the future arrangements for diverting those with mental health and learning disabilities away from prison. All recommendations were accepted by the government, subject to further analysis of cost and resource requirements, and now form part of the delivery plan.

A full report on this consultation, *Lord Bradley's review into the diversion of offenders with mental health problems and learning disabilities away from prison, capturing the views of stakeholders: a summary report of consultation events* is available on the DH website[7] and contains a full list of those consulted during this process. An independent evaluation of the consultation is also available.

EIA Consultation

A period of consultation ran from July to October 2009 to engage directly with offenders within custodial establishments and ex-offenders in the community. The testimonials provided via this exercise gave a useful insight into experiences within, and journeys through, the CJS within the context of their health and social care needs. Individual multi-identities proved a key consideration, needing recognition whether by ethnicity and gender, disability and sexuality or a different combination of any number of the seven strands. Each person is unique and their specific needs should always be determined by personal considerations.

Focus Groups

The bulk of the EIA consultation was carried out via focus groups, which are proven as a reliable and valuable means of gaining data to improve services and gain consumer or user insight. Originally developed to market test new products in the United States in the 1970s and 1980s[8], this qualitative approach is now used widely in business, governmental and academic institutions to seek the views of existing and potential users of a service and/or or products that can shape and develop an intervention. This is equally relevant within the Offender Health policy framework. Indeed, Watts and Ebbut[9] have highlighted the relevancy of this approach when seeking the

[7] www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098701.pdf
[8] Stewart. D.W. & Shamdasani P N (1990) Focus Groups, Newbury Park London.
[9] Watts M and Ebbutt D (1987) more than the sum of the parts: research methods to group interviewing, British Education Research Journal 13, 25-34.

views of established groups. In this context, offenders within custodial and community settings via membership of established groups (e.g. support groups).

Offender representatives for each of the seven strands were recruited within custodial establishments as well as ex-offenders in the community by working closely with HM Prison Service (HMPS) race or equality leads across the country. Resulting focus groups were further enhanced by a number of individual consultations and interviews with ex-offenders represented by a number of non-statutory sector organisations, including NACRO and the Prison Reform Trust. This allowed the EIA to benefit from the perspective of former offenders and the valuable insight they can offer into the health, social care and criminal justice pathways.

Focus groups were held within prison establishments, usually in the presence of an HMPS representative (i.e. the equality lead), for security reasons. One-to-one interviews were also conducted to gain a more in-depth knowledge of any concerns or issues that may have had, or be having, a negative impact on the individuals involved. Each session was documented by a facilitator, and a discussion group was held with all facilitators to draw out emerging key themes and issues. Perceptions and other feelings emerging from the focus groups were also discussed in this debriefing.

Like all methods, focus groups do, of course, have their limitations. Robson[10], for example, states: *"It is difficult or impossible to follow up the views of individuals; and group dynamics or power hierarchies effect who speaks and what they say".* An additional risk to this method is that a few individuals may dominate the discussion. The EIA process therefore made use of the following techniques to mitigate the impact of such risks:

- Briefing facilitators and note takers on how to effectively facilitate and record a focus group discussion
- Using inclusive techniques to ensure each participant has a voice, including:
  - using an ice-breaker at the beginning of the meeting to aid introductions
  - responding to those who dominate the discussion by actively engaging, via encouragement and support, with participants who have not spoken.
  - Offering each participant a 'final say' as the discussion concludes, and allowing 'pass cards' for those who do not wish to take advantage of this. This method may be used at various points in the discussion.
  - Arming facilitators with key prompts to maintain the flow of dialogue and ensure a consistent and relevant discourse
- Individual interviews were also offered at the end of each session to follow up any personal thoughts that could not be articulated within

[10] Robson, C (1993) Real World Research Blackwell, Oxford. p241.

the group. These one-to-one interviews resulted in a biography of the offender's journey through the CJS from a health and social care perspective.

Question Set

Discussions were structured around the following sets of key questions according an approach developed by Race on the Agenda, and modified for the purposes of this EIA (see also *Human Rights Review below).*

Starting Question: *What are your experiences of health and social care in your journey through the criminal justice system?*

Prompts

- Police (arrest and custody, mental health assessment, drugs, medication)
- Court (pre sentence, reports, court diversion, legal advice, community sentence options)
- Transfer to prison
- Prison (reception, screening, access to healthcare, GP, nurse, medication, drug treatment, mental health assessment, dentist, hospital care)
- Pre release and resettlement, support, registration with GP
- Other - food, exercise, environment, culture appropriateness, gender sensitivity, family visits, relations with officers, staff in healthcare.

These prompts were in turn related to the seven strands of equality within the context of this journey. The primary aim of this approach was to capture any negative experiences and positive suggestions for improvement:

Race	As a person of colour, or with distinct cultural or racial needs, did you have any negative experiences? Do you feel you were treated differently to other groups accessing the same services?
Gender	As a woman/man, do you feel you were treated differently to other groups in accessing the same services? Was the service gender specific? How could it be improved? What worked well for you as a woman/man?
Gender Reassignment	What are your experiences related to your journey through health and social care? Were the services/experiences specific to your needs? How can they be improved? Which specific areas/services?

Disability	Do you consider yourself to have a disability, whether physical, sensory or learning? Have you asked for support or help in finding out (learning disability?). Do you think that you have been treated differently to able-bodied people as a result of your disability?
Sexual Orientation	Do you think services you have accessed, or have been unable to have access, to be homophobic, (not open to gay, lesbian and bi sexual people?) Do you feel discriminated because you are gay? Are straight (i.e. heterosexual) people treated differently to you? How and where?
Age	Do you think your age is a factor in you being able to access, or not access, any health services? Social care services? Are there specific examples you can give of bad experiences or good practice? What has worked well for you and not so well?
Religion or Belief	Have you been provided with respect and the right to practice what you believe? Have you had access to religious facilities and / or objects you need to practice your faith? (Bible, Quran, Torah, Halal, Kosher, vegetarian food, Mosque, Temple, Chapel etc,. Chaplain, Rabbi, Iman, etc.) Can you share any experiences that offended your religious belief and any that you felt supported your belief?

Whilst the delivery plan was in development, the project team was asked to assess the recommendations of the Bradley Review, which would form a core component of the final document. Given that the focus groups were not specifically themed for mental health and learning disability, a hypothetical scenario was therefore given to respondents to solicit experiences related to the recommendations. Those present offered their own experiences and views on how the service can be improved.

Human Rights review

This aspect of EIA spotlighting the Human Rights element was reinforced by a review of the delivery plan by a Human Rights Specialist (Dr. Theo Gavrielides) from the organisation Race on the Agenda. One to one interviews and focus group discussions were also assessed and findings on adverse impact provided. These reviews were provided to DH Offender Health to consider in the development of policy and strategy. The work was contextualised within an empowerment and rights model that could lay the foundations for consideration and future outcomes. Full transcripts of these reports can be found in Annexes B and C.

The Department of Health and the British Institute of Human Rights have collaborated with some NHS organisations to apply a human rights based

approach to service delivery that can compliment this section. Further guidance is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088970

The Evidence Base

This section contains a summary of the data collected via the literature review [11](see Methodology) published in 2009 in support of the EIA. Alongside this, key findings, gained via the consultation process are outlined, combining national reports with local evidence provided by offenders and ex-offenders.

Race

People in contact with the criminal justice system[12]

The MoJ reports that members of the Black community are:

- Seven times more likely than their White counterparts to be stopped and searched
- Three and a half times more likely to be arrested
- Five times more likely to be in prison

Police[13]

- Black victims (27 per cent) were more likely to be shot compared with Asian (8 per cent) and White (5 per cent) victims.
- In England and Wales in 2006/07, the arrest rate for notifiable offences for Black people was 3.6 times higher than the rate for White people. The rates for people in the Asian and Other category were closer to that for White people but still higher.
- Members of the Black community are seven times more likely than their White counterparts to be stopped and searched.

Courts[14]

- The proportion of charges terminated early (discontinued or withdrawn) were similar for White (20 per cent), Black (21 per cent), and Asian defendants (21 per cent).
- Nearly twice as many Asian defendants were committed for trial (33 per cent) than White defendants (17 per cent).

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[11] *Offender Health and Social Care Strategy Data Report,* DH, March 2009

[12] The primary source for this data is *Statistics on Race and the Criminal Justice System - 2006/7* (MoJ 2008).

[13] The latest British Crime Survey (BCS)

[14] The statistical report presents data for both Magistrate and Crown courts. However, in all but seven geographical areas[14] the ethnicity of the defendant was unknown in more than 25 per cent of cases in Magistrate's courts: '*This makes it impossible to identify any ethnic differences in court decisions at a national level'* (p 58). The differences found in the seven areas are likely to be indicative of the national situation.

- Nearly a quarter of all Black defendants were committed for trial (23 per cent).

- 73 per cent of untried receptions in 2006 were of White prisoners, 14 per cent were Black or Black British, 7 per cent were Asian or Asian British and 3 per cent were from the Mixed group[15]

Probation and community services

- Black or Black British (six per cent) made up the largest minority ethnic group of those starting probation or community services. 15 per cent of males were from a minority ethnic group compared to 11 per cent of females.
- Offences committed by Black young offenders were more likely to attract a custodial sentence then offences committed by other ethnic groups [16]

Key Consultation Findings

Amongst Black and Minority Ethnic offenders (BME), a number of interlocking issues arose from accounts of personal experiences and perceptions. Most notably, there was some feeling of racial discrimination regarding how they were treated within the prison environment. This seemed to manifest itself most within the level of incentives and earned privileges they were allowed, with many feeling that they had not been given such privileges which allowed them more freedom and a sense of independence. Cultural appropriateness of mental health services is a particular issue in these cases. The development of cultural competencies for offender healthcare staff would mitigate this issue and support staff as well as individuals in prisons.

Little difference was evident between male and female BME offenders, with each sex experiencing a level of anxiety and depression that was not recognised within a cultural framework. Cultural issues, such as access to Halal food, were raised with the extreme example of a prisoner being given pork sausages on the specific understanding that they were Halal, only to discover later they were not.

"I used to think prison governor was doing their job they should have thought of giving us proper food, I used to be able to afford some food from outside but what about those less fortunate, I used to get ill for two days on and off and kept the fasts they gave rice a Child's portion I told the prison staff and next day I used to get an apology and fasting all day we used to get a Child's portion and with hunger a person loses weight, I used to get worried a lot, depressed a lot, I used to eat a lot of tablets for depression, they used to give tablets only." **Asian female respondent, Pakistani origin.**

[15] OMCS 2006
[16] Statistics on Race and the Criminal Justice System - 2006/07, p.17.

Some BME offenders provided testimony of bullying from other inmates on racial grounds.

"While I was in prison 1997 eleven years ago, I did experience racial discrimination and experienced it underhandedly when it came to trying to towards my parole in every angle I was being blocked, the prison I went to was all European if I was not the only black person there was only one other. I had a drug problem when I was in prison but I cleaned up in prison off crack cocaine, done loads of education and other courses and qualified as a fitness instructor NVQ level one and two, computer courses, etc I was moved from X prison to a prison in X and that's where I found was my worst experiences, that part of the country there was lot of racial discrimination going on, hard core, people working in the gym who were less qualified than me, (other offenders) I suffered racial abuse from other inmates that time 1998, I was attached in the prison by a welsh European young man (20's) and I nearly lost my eye.

That happened a few months later on another European guy had a fight this time I defended myself and I was taken from my cell and put in a block spent seven days in solitary confinement and shipped to X which was for punishment, when I got to X I was then told, that I would have to go into solitary confinement because the prisoner I had a fight with was also there and he got to X prison before me and they could not have two of us in the same prison. I was put into solitary confinement which once again was wrong". **Black British Male**

One disabled black British male respondent felt that he would not have had access to a job in prison if it were not for his disability. In other words, he felt sure he would not have been considered for work on the grounds of ethnicity:

"Not openly or directly. Last prison I was in, in X, and it comes down to what different areas you are. I mean I'm kind of used to a slight negativity now and again. There's nothing openly direct, you just need to go and look around and see who's got what jobs. There is a little racist thinking going on, I think". **Disabled Black British Male respondent on negative experiences in prison due to race**

A particular issue for foreign nationals, and equally for older non-English speaking people in the CJS, is the use of interpreters in the early stages of imprisonment:

"Four weeks in healthcare at risk of suicide, they used to look in from the window, three was some good ones and some bad ones nurses from the hospitals, I used to cry all the time, I did not understand a teacher used to come to teach me English, there was no interpreter in prison, when they took me out of healthcare took me to education, I took up sewing, there was no interpreter, and without interpreters they used signs, no person or another prisoner who could interpreter just using signs" **Female African respondent**

White respondents meanwhile, often the majority group within custodial establishments, had a perception of being unfairly treated in comparison to offenders of other races. This was particularly the case in respect to religious

and cultural dietary requirements. It is not an uncommon perception amongst majority groups that specific minority groups are receiving 'special' treatment. Although this may constitute an incorrect interpretation of a drive to address existing inequity, it is important that we address the duty to *promote good relations* in these cases.

Race In Conclusion

There is a perception amongst those interviewed that some of their cultural and religious issues were not being met, although we are aware that great strides have been made in this area by some criminal justice agencies, there may be room for improvement. Perceived gaps in provision are impacting on mental health and general wellbeing. Evidence shows the over representation of specific BME people within the CJS, including those arrested for offences that may arise as a result of their severe mental health condition not having been addressed in the community. The diversity of offenders based on racial and cultural identity needs to be recognised to support an appropriate level of health and well-being.

Religion and Belief[17]

The national picture

- 72 per cent of offenders identify themselves as Christian.
- People with no religion formed the second largest group, comprising 15 per cent of the population
- 6 per cent of the population belonged to a non-Christian religious denomination

People in contact with health services

Lack of available analysis.

People in contact with the criminal justice system

Police

We found no recording of religion and belief in data routinely recorded by the police.

Courts

We found no recording of religion in court data.

[17] The religion question was the only voluntary question in the 2001 Census and 7.69 per cent of people in England chose not to state their religion.

Prison

- On 30 June 2006, the largest group of prisoners were those with no religious affiliation, who accounted for 33 per cent of the prison population.
- The other main groups were Anglicans (30 per cent), Roman Catholics (17 per cent) and Muslims (11 per cent). Of the other religious group category, 270 prisoners (68 per cent) were Pagan.

Probation and Community Services

We found no recording of religion in probation data.

Key Consultation Findings

Most offenders experienced positive outcomes when related to their religious needs primarily due to the work of the chaplains, Imams and other contacts within prison. The main area of concern found related to religion or belief was access to appropriate cultural diets, such as Halal food, as referred to earlier in the section on race.

> *"They gave me some sausages and said they were Halal I could see that they were not so I didn't eat them"* **Black Male Muslim Convert**

> *"Seems to be a problem in this area as on a Sunday in particular, non Muslims get a variety of foods including bacon and so on. Muslims on the other hand (as they eat halal) only get things like, 4 fish fingers and some beans or a jacket potato. So they do not get a big portion. The portion size apparently is getting worse"* **Black Male Muslim**

Within the older population, access to religious practices is more important (with the caveat of the increase in the number of followers of Islam in custodial establishments, particularly amongst the young). No major issues were raised relating to healthcare provision. However, this does not mean none exist but more likely have not to have been highlighted in this discussion or in the focus groups.

Although Muslims predominantly complained of the lack of variety of Halal food, essential to their religious belief, this is equally an issue for those of a Jewish faith or smaller denominations with strict religious dietary needs such as Hindus or Sikhs. Food for religious festivals was also an issue:

> *"In Ramadan (Islamic month of fasting) is bad. Basic food is given which is minimal. For Eid, the food was for everybody on a table so not much to go around. No food is allowed from the outside on Eid day for security purposes".* ***Muslim***

This theme was echoed by both males and females, and it was apparent that they felt the fulfilment of this religious obligation had a direct impact not only on their personal well being but also on their mental health.

The right to practice one's religion was not an issue universally. However opinions did vary with respect to having appropriate religious material available or an understanding from staff of certain religious practices. The following views represent a range of experiences that are both positive and non-affirmative:

"Officers walk in front of us while we are praying (not allowed in Islam whilst a person is in prayer, sometime they would walk in the prayer room with their shoes on. But recently, there seems to be an understanding of this wrong" **British Asian Muslim.**

"The Quran, Bible or Torah are available in here" **White male Christian**

"Why isn't Bible wasn't given to prisoners anymore, it was normal before" **White Male Older Offender**

Through these discussions, it became self evident that religion and belief played an important role in the lives of offender:

"As a Muslim there is nothing in place. A lady should come in every Thursday but haven't seen her for a few weeks" **British Asian Muslim Offender**

"Faith matters' group facilitated by Chaplaincy has open discussion about different issues, its a. good services for Christians as there are more volunteers based in the prison. They come here more often" **White British Christian Female Offender**

Religion And Belief In Conclusion

Religion and belief are seen as an important part of identity when in prison, and concerns centred on the availability of appropriate food to meet religious beliefs as well as other spiritual requirements. Experiences of support varied across custodial establishments, dependent on how effective Chaplaincy and other services responded to individual and group needs. The diverse religious and spiritual needs as well as catering for those of no religion and belief have to be considered in regard to impact on health and well being. More research into this area is required to enhance the existing low data available to help develop appropriate services for the diverse offender population.

Age

This section focuses on young offenders and those aged over 50, who are most likely to experience discrimination or issues related to their age.

The national picture

- The population will gradually become older with the average age expected to rise from 39.6 years in 2006 to 40.6 years in 2016, and 42.6 years by 2031[18].
- The proportion of people aged 65 and over is projected to increase from 16 per cent of the population in 2006, to 22 per cent by 2031.

People in contact with health services

- The great majority of health statistics are disaggregated by age. Self-reported ill health and disability increases with age as does the incidence of most major diseases.
- Because of increasing life expectancy the length of life spent by older people in poor health or with a disability may be increasing.

People in contact with the criminal justice system

Police[19]

- Of all persons arrested almost a quarter were under 18 and nearly 40 per cent under 21.
- The most common offence group for arrestees aged 10 to 17 was theft. For both males and females aged 18 and over there were more arrests for violence against the person.

Courts

- Those aged over 50 represent four per cent of the total number of people starting Community Orders.

Key Consultation Findings

As previously stated, a separate EIA is being undertaken for Children and Young people in the CJS. This group were therefore not examined in detail during the consultation.

As the prison population becomes older, there is a need to address a number of key issues specifically related to the health, social care and well being of older offenders. A number of related issues emerged, namely a sense of isolation combined with generational differences:

"We all agree, younger people go out in prison, do other things. But we are different, when you're older; you think the younger ones are lucky. It's difficult for us". **White older male respondent**

[19] Source: Arrests for Recorded Crime (Notifiable Offences) and the Operation of Certain Police Powers under PACE England and Wales 2006/07 (MoJ July 2008), p5

A sixty-seven year old gentleman referred to feeling slow and the sense that everything was moving too quickly around him:

"We say hello to each other but we don't mix, they ask for milk and that sort. I don't play pool or anything with them. I can't go up and down with them I just sit inside and watch TV" White **older male respondent, on younger prisoners**

There was a general consensus amongst the older prisoners that a much felt dissatisfaction with health care services stemmed from the needs of other groups being visibly catered for - gym facilities for the younger population, a variety of religious items available on the canteen list, but no age specific services or products.

'Young man's game, it caters for the young who go to the gym and all that. They are different, they think different". **White Male Older respondent, on prison**

It was felt that the prison staff needed an age specific attitude, showing dignity and respect.

"They treat you like kids in here. We're grown up. I know we're in prison but to talk to us like they talk to the younger lot is absurd" **White, male, older respondent**

The impact of disability was evidently felt more by the older population, who have increasing social care needs. Issues included:

- Not being given pillows to support back and shoulder problems
- Trust and confidence in doctors, including being given a paracetamol or ibuprofen for aches and pains needed more effective, long-term, treatment.

"I was involved in a car crash once but I still get pains in the side of my neck, I told that to the doctor and without him even looking at me said take paracetamol." **White, male, older respondent**

- Not being allocated a specific nurse to ensure better continuity of care
- Ineffective alarm systems (e.g. cell buzzers)

"You press it and the guards take 45 minutes to arrive. Now, I have had a stroke in that time before, and I nearly died. 45 minutes response time is too long" **White, male, older respondent with heart condition on cell buzzer system**

Several respondents were keen to take some responsibility for their own medicine management, given the certain level of independence this would allow. However, the propensity for abuse of such an arrangement within the prison environment makes this a complex area.

On visiting the GP, some prisoners felt their health needs were not being fully met, with very basic health advice being given. One gentleman even claimed that whatever the medical problem was the GP's answer was to 'lose weight and you'll get better'.

"You get asked two things when you see the doctor in here, do you drink? And do you smoke? If you say yes to one he tells you to quit and you'll be fine, if you say no then he's stumped and just gives you paracetamol" ***Older respondent***

"The doctors are terrible. It takes a long time to see them, like five to six days, and when you do, they don't even look at you and tell you to either lose weight or take paracetamol. You complain of something and the answer is always the same. For this reason, I always now check everything with my daughter who's a microbiologist, you know, about medications and things". ***Older respondent***

Concern was also expressed that adjustments were not being made for older offenders to address their specific needs (e.g. accessing medication at the pharmacy):

"The pharmacy is useless too, for a start, you got to bend down to speak to someone or collect your medicine. It's so far down that someone with back problems wouldn't be able to see what they got, let alone talk to them in there" **White, male, older respondent**

These concerns were also replicated amongst female respondents. Another reoccurring theme was that of food and the lack of quality and catering for those with diabetes or other special dietary conditions, which left them unable to manage their condition properly:

"The menu is always the same. They don't cater for us diabetics. There's no special diet included in there for us like yogurts or diabetic chocolates or even jam. We're being discriminated against. You've got the entire list, like for religious groups like what they can and cannot eat, but yet we have nothing" **White, male, older, diabetic respondent**

"Poor and you can't buy fresh fruit" **White, male, older, disabled respondent on canteen**

There was also a very limited selection of vitamins and minerals available for the prisoners to buy and those that were available were at very high prices. One pack of vitamins was priced at over half of the weekly spending allowance. However, there was also evidence of good practice:

"In X prison they would have these diabetic packs supplied in canteen. There was a guy who would make special trays for diabetics that catered for their needs, but here, it's always the same food" Older **White, male, diabetic respondent**

Clearly, needs could be met with consistent practice across the pri son estate for offenders with special dietary needs related to their health condition. Diabetic prisoners should be able to manage their diet carefully even without the specialist diabetic packs.

Age In Conclusion

Older people's needs are completely different to those of the younger generation. Trust, dignity and respect were a major feature debated in the consultations, coupled with a lack of sense of independence. Long term conditions also need to be addressed in linking healthcare needs with security concerns within a prison environment. It is important to recognise the sense of isolation older offenders feel when in a mixed-age prison, with television their only comfort. This may lead to anxiety and depression, and unmet social care needs. It also has the possibility of affecting their mental health and well being.

Disability

The national picture

- It is estimated that there are about 11 million disabled adults in the UK - one in five of the total adult population - and 770,000 disabled children[20].
- Disabled people have a wide variety of impairments, and every disabled person will face a different combination of attitudinal, physical and socio-economic barriers.

People in contact with health services[21]

Information on the health of disabled people is less readily available. Comparison between disabled people and others is complicated by the connection between health and disability in common definitions, and the interaction between the presence of impairment and the individual's health.

People in contact with the criminal justice system

[20] Prime Minister's Strategy Unit (2005) Improving the life chances of disabled people. http://www.cabinetoffice.gov.uk/strategy/work_areas/disability.aspx

[21] Figures on the prevalence of disability are available from a variety of sources including the Census and major population surveys. The definitions of disability used vary. For example, the Census and General Household Survey refer to 'a long-standing illness or health condition which limits your activities'. Work is in progress in 2008-09 to harmonise disability definitions, and the new Disability Survey of Great Britain will collect substantially more data.

'*No one knows*' (Prison Reform Trust 2008) reviewed the literature on prevalence of learning disability among offenders. It is a difficult area with no precise estimates.

- 20-30 per cent of offenders have learning difficulties or disabilities that interfere with their ability to cope within an institution.
- 40-50 per cent of prisoners are at or below the level of literacy expected of an eleven year old with dyslexia three to four times more common among offenders.

Police[22]

No data is available

Courts[23]

No data is available

Prison[24]

The Prison Service does not currently collect data on disability and are exempt from some legislation concerning disability.

Probation and community sentences

No data relating to disability for probation or community services.

Key Consultation Findings

This area covers both physical and learning disability of offenders. Although the majority of physical disabilities are self evident, others, such as mental health and learning disabilities may not be. The following paragraphs cover a number of case study interviews, highlighting the experiences of offenders with disabilities within the CJS.

One deaf offender, speaking of his experience at early screening entering custody and prison, said that although his impairment may be recognised it is

[22] Figures on the prevalence of disability are available from a variety of sources including the Census and major population surveys. The definitions of disability used vary. For example, the Census and General Household Survey refer to 'a long-standing illness or health condition which limits your activities'. Work is in progress in 2008-09 to harmonise disability definitions, and the new Disability Survey of Great Britain will collect substantially more data.

[23] The report *Criminal statistics: England & Wales (MoJ 2006)* contains no reference to disability.

[24] Stewart (2008) in a survey of prisoners arriving in prisons found that over a quarter (27 per cent) of the sample reported a long-standing physical disorder or disability.

not communicated to other staff, particularly those on the wings. Another individual raised communication as a key issue, especially being able to have a dialogue with key health professionals and others to ensure his needs were met:

"Healthcare is pretty good would be good to have a sign interpreter, people with strong accents gets lost in the communication I can't understand, the dentist also is a problem, wearing a mask can't understand what he is saying. At hospital I need a sign interpreter, do not have one in audiology can't always understand what the doctor is saying." **White, male respondent with hearing impairment speaking of some of the barriers he has faced.**

A simple issue such as having access to a TV with subtitles is important, but can take a considerable amount of time to obtain. This may lead to isolation and levels of depression that may overlooked by staff in healthcare or secondary care services.

"Good communications, equipment is there when I need it for example the loop system, another example TV with subtitles waited for a TV with subtitles it was when it got to the residential governor that it happened quickly. Equipment should be there on standby." **White male respondent expressing good practice solutions to meet his needs.**

"Extremely lonely to have hearing problem, when someone say's something to me and you has got it wrong can cause problems. I do get anxious bunch of guys make a joke don't understand it, a lonely place it changes your socialization skills don't hang around too many people

"Some boys mock that is hurtful, when they do that, when you are working someone may call you, you think they have called you but they haven't say are you deaf? Yes I say". **Young offender highlighting personal concerns and anxieties.**

Appropriate support is essential in a CJS setting to ensure good health and well being, alleviate alienation and isolation and prevent someone being perceived as 'different' by others:

"Support groups such as RNID come in not that happy with support not people of my age much older deaf people such as the chaplain another woman but not young people." **Young male offender suggesting the most appropriate need.**

In another case study, one offender highlighted the need for a seamless healthcare service throughout the CJS to meet the specific needs of his disability.

"Well to be honest, with my case in particular having a trachea operation it's not the norm. At first people weren't geared up for it. So as far as the police were concerned, obviously there on edge, a little bit care like, daily care, like to clean this daily I'd take good care of it, so the police station was difficult. As you can see I've got a talking mechanism, which I use regularly, it's difficult to speak without so, realistically, I didn't get care at all. my wife phoned up and explained to the police I needed the pieces to clean the throat and stuff like that, but I didn't get it full stop. I was in the police station for three days. So you know I had to make do. As far as prisons concerned, when I got in, there was a nurse at reception and she didn't fully know about my condition, but she knew there would be a little problem on day to day care and stuff, so she made sure she got as much info from me as possible on the day, which was helpful. As far as the staff, it took them around a month to understand my needs. X (Prison Diversity Lead) was quite good; he would do something about it. When I was in prison long before, you felt you had to fit in, but in this day and age, it seems more care is given to people with different disabilities, so in general, it hasn't been too bad" **Black male respondent with a tracheotomy reflecting on his experience in police custody**.

The specialist care required by the offender needed recognition and appropriate services provided. As the offender highlights, secondary care was not always able to meet the needs related to his medical condition:

"Well, the one thing that did happen was I was sent to hospital, but that was cos I started to have medical problems rather than them saying, "Oh we better make sure this man's alright". I had problems breathing, an example of my problems, not all hospitals have the equipment I need for my problems. I have to have the valve in and kept open. If not, I have to have the operation again. The hospitals, it's quite difficult. They can see that, obviously something is wrong with me to look at me, with a hole in my throat, in hospital, I need some kind of care, but it's the balance of how much care I need, that has been quite difficult. I mean, the nurses and prison staff here, they have tried to make sure that my needs are met but even some of the medical staff aren't fully aware of exactly what I need". **Respondents experiences accessing secondary care as an offender.**

Primary care and dentistry were two areas raised by this offender, echoing similar issues raised by other respondents in respect to the level of service received from doctors. Dentistry and access to the service has been raised by a number of respondents. A patient having a particular disability adds a further dimension to their needs, and should be assessed in line with the DDA requirements and appropriate arrangements made.

"I've been here nine weeks or so, and I've seen five different doctors and only one of them and two of the nurses are geared up and know a little bit about it. The doctors, three of them, to be blunt, didn't have a clue what day it was let alone what treatment I need. I had to keep explaining. I've only seen a dentist 8 weeks ago, it's frustrating. I understand it's the prison situation, but it's not good enough and second rate. There is definitely a big gap in the service outside of prison and inside, inside is second rate." **Respondent assesses healthcare provision in the community and his experience in prison.**

The final case study raises concerns over the lack of understanding of an offender's particular condition, namely his height and disability. He was not given access to a shower and had a long wait for an elevated toilet seat:

"From the first I was arrested, not a problem because, I wasn't arrested out in the street, the police came to my door and I voluntary took myself down the station. Didn't have good to see in or toilets in police station for disabled access. They were just about happy with me to sit on side of an arm of chair, because they didn't have any high chairs. But they weren't happy with me standing, which was not too bad. Got the call, obviously, the judge likes you to sit, had to explain my circumstances that I couldn't sit on one of their chairs. He let me rest against the back top of a chair. From there, obviously went to the court cells, there were no benches that were high enough for me in the cells. The only thing I could do was lay down in the cells in the courts when it comes to transportation, all they've got are the vans, which are small cubicles with low seats in. I had to remain stood in the journey, lucky I was only 15-20 minutes in van coming to prison, but I stood up. Had there been an accident or something, then obviously I'd be in a lot of trouble. I had to explain to officers here that I couldn't do stairs; I needed some bits and pieces. They put me on the health care wing. Now, I think between shift changes, the verbal between two shifts was not very good. So by the time the next shift came along, they didn't know what was wrong with me. That's carried on for over a week. Still, I'm getting officers like "come on, come on, hurry up!" am like ''officer, I'm disabled, this is the pace I go at''. Some of them accept it straight away; others get grumpy cos it slows their routine down.

But they need a bit more communication between shifts and especially between health care and the main prison. Because I was on health care for the first four days, where I thought I was going to remain the toilet there was ok for me, the bed was good as it was a 'bar' bed . Somewhere between shift changes I got shifted from health care over to here. A couple of officers came back the next day and asked "why you here?" I was like, don't no, I got told I had to move cells, so I don't get IEP's against me and shifted down the grades and loose any of my bonuses and benefits that the officers can offer me, I had to move.

Most the officers have been quite good, but when you consider how many inmates there are to each officer, it's really difficult. But I think the problem is, there just not really set up for disabled people. It's hard, I've only been here a week. The beds are all wood; I have got no way of getting myself out of bed in a safe manner. The toilets are too low, I've been asking for a booster seat for a week, but still waiting. It's a slow process just to get a plastic booster seat". **White male respondent with a disability reflecting on his experience through the criminal justice system.**

The offender highlighted a disconnection between his needs as a disabled offender with a distinct medical issue and the prison regime, leading to an adverse impact on his medical condition and a detrimental outcome:

"When I was with health care, I was alright, I was on ground floor, and the exercise floor is the same floor, so I was able to go out for exercise. Over here, it's a flight of stairs to go down and up. It slows the whole wing down, so I've stopped going down for exercise. But health care was quite reasonable; they gave me medication on time and checking up on me. But now, I've moved to here, they don't care" **Disabled respondent highlights some of the barriers he faces for some minor tasks.**

In other cases also, disabled offenders with specific needs have spoken of the lack of mobility related to their condition:

"Disabled are an inconvenience to staff, I'm diabetic, wasn't getting my special sugar for diabetics. I had to go to the kitchen manager and complain if it was being dealt with. The problem was like that for two weeks, but then it was ok. But the officers are used to deal with 500 prisoners and we disabled seem to be forgotten, once I asked something for my legs, for some cream to be put on as they were in pain. They told me that they won't do it as I wouldn't get it done on the outside of prison on this day" **White, male, older, disabled respondent (wheelchair bound)**

"The healthcare wasn't bad, if they see a genuine case of disability, they do try to help" **White, male, older, disabled respondent**

Disability In Conclusion
Overall, this indicates that the needs of disabled prisoners are not being met within prison. Better facilities and resources should be made available to improve the health and well-being of the disabled population. Many claim that discrimination and a lack of awareness for disabled needs is commonplace within establishments, from both prison and healthcare staff.
Issues related to reasonable adjustments and compliance with the DDA are central to these concerns as are appropriate and responsive healthcare provision and aids that support specific needs.

Sexual orientation

The national picture

At present, there is no official estimate of the lesbian, gay and bisexual (LGB) population although it is estimated prevalence of the LGB population is 2%.[25]

People in contact with health services

No national health statistics are available broken down by sexual orientation.

[25] Based on small scale quantitative testing on the National Statistics Omnibus Survey,

People in contact with the criminal justice system

No routine sources of data that include information about sexual orientation in relation to the CJS.

Police

No data or relevant literature.

Courts

No data or relevant literature.

Prison

- There seems to be evidence that the experience of prison is more likely to have an impact on women in terms of their sexual orientation than men.[26]
- Gender, race, homosexual behaviour during incarceration, and remaining sentence time had statistically significant effects on inmates' attitudes toward homosexuality.[27]

Probation and community sentences

No data or relevant literature.

Key Consultation Findings

This area was limited given the sensitivity in prisons and people wishing to protect their personal confidentiality and sexual preferences, particularly in respect to those who are bisexual. The limited contact made with homosexual offenders raised issues related to mental health, counselling support and access to specific healthcare issues such as condoms.

Discussions and interviews made clear that openly gay, lesbian or bisexual people felt very vulnerable in the CJS.

[26] Peplau and Garnets (2000) claim that: '*Women's sexuality and sexual orientation are potentially fluid, changeable over time, and variable across social contexts regardless of sexual orientation'*. In particular, they highlight prison as an example of a restricted setting in which women may choose same sex relationships.

[27] Hensley (2000) in a survey of attitudes among 256 male and female prisoners in Mississippi

"I made a mistake of being too out they gossiped about me and gave me dirty looks in the police station making snide comments, especially when I had the cavity search they commented that I was enjoying it" **White bisexual male speaking of his arrest and experience in custody.**

Others spoke of similar experiences as gay people upon arrest:

"*They crack funny jokes and make you feel small they like to be macho and I find them really homophobic"* **White gay male respondent arrested for a minor offence.**

"The most likely way you are going to come into harm is getting aids from him doing you" Gay **man relating an experience when caught in a car with a working girl by the Police.**

Sexuality was also used against them by fellow clients when accessing healthcare services in the community:

"I was in a drug rehab centre and I made a comment about loving to look after my own children and a rumour started that I was a paedophile by someone else in the group" **Bisexual male highlighting further stigma in the community.**

Several gay and bisexual respondents voiced their fear of going to prison, feeling that other heterosexual offenders may abuse them. Some questioned whether there would be any safeguards:

"My worst fear about going to prison is being raped by another prisoner." **Gay *male offender.***

"Would be worried if they didn't use condoms where you would get them from?" **white gay male offender in the community.**

"*I would be worried if other women found out if I was a lesbian some would be okay with it but others, well they think you are just not natural"* **White Lesbian ex-offender.**

Amongst heterosexual people, there was a perception that gay and lesbian people received better services:

"The lesbians get a better screening programme than we do and we need it too." **White heterosexual female comparing access to services for her and other groups of offenders in a woman's prison.**

Sexual Orientation In Conclusion

Stigma and discrimination in the CJS were a major fear of gay, lesbian and bisexual people who took part in this consultation. Sexuality was seen as a personal and private matter than needed to be respected by all professionals. Support and fear in prison was an issue also highlighted with people feeling unsafe with other offenders who may disrespect their sexuality, leading to physical or emotional abuse. The impact on personal emotional and general health well being needs to be considered in the light of these comments and appropriate support consiered.

Gender

The national picture

- There were 25.8 million females compared to 24.9 million males in the mid-2006 population of England.

People in contact with health services

The great majority of health statistics are disaggregated by gender.

- The life expectancy of women is greater than that of men. However, women tend to report higher rates of self-assessed ill health and disability.
- Patterns of illness differ by gender for both biological reasons (e.g. cancers of the reproductive systems) and social reasons (e.g. drinking and smoking behaviour).

People in contact with the criminal justice system[28]

- In 2006/07, 83 per cent of those arrested for recorded crime offences were males, the same as in 2005/06.
- There was an increase of 4 per cent in male arrests and a 2 per cent increase in female arrests. Male arrests increased by 48,600 to 1,230,700 and female arrests by 3,800 to 251,500.

Courts

[28] Key points from the statistical bulletin *Arrests for Recorded Crime (Notifiable Offences) and the Operation of Certain Police Powers under PACE England and Wales 2006/07 (*MoJ July 2008, p.3*)*

See Criminal Statistics Annual report[29]

Prison

- Men are more likely to be on remand for violence against the person, other offences and theft and handling
- Women are more likely to have psychotic symptoms, personality disorder, anxiety or depressive symptoms and to have attempted suicide in the previous year or be self-harming.

Probation and community sentences

- OCMS report that 15 per cent of those starting Community Orders in 2006 were female and the number of males starting all community sentences has increased gradually between 1996 and 2006, rising by some 9 per cent over that period.

Key Consultation Findings

In the interviews, women spoke of their experiences through the CJS in relation to health and well being. Within the police custody setting, many felt that they did not have access to adequate health provision. As offenders, they were also seen to be untruthful about their health conditions. This seems to mirror comments made by men, particularly those with disabilities or older offenders when stating their medical condition. Both males and females felt health provision, understanding and care were least positive in this setting.

Women commented on their experiences in police custody:

"I told them I was claustrophobic but they said, 'that's what everyone says', I felt vulnerable in the cell" **Black British young female**

"I told them I was pregnant they told me to prove it" **Black British Female**

"I can't bend my left leg, told them I had a disability, they didn't believe me, they told me to bend it and bend it" Black **Jamaican Foreign national offender recalling her particular experience at the airport on being arrested.**

One woman raised concerns related to her alcoholism:

"I have a drink problem wanted to see a doctor had to wait two days to see a doctor, I'm an alcoholic" **White older female wishing to access primary care.**

A drug user complained of not having access to methadone whilst in police custody.

[29] www.justice.gov.uk/publications/criminalannual.htm

"In X the service was poor you had to fill in the slip even for paracetamol and queue up with all the offenders wanting methadone. In Y they had dispensers and you used a fob you got from the nurse to get paracetamol or ibuprofen, that was better". **Black Caribbean female speaking of her experience at a local prison and compared it to one where she travelled to out of her county.**

Amongst men, there was a similar negative experience of police arrest and custody with most complaining of their healthcare needs not being assessed when they were arrested or taken to the police station.

"I was arrested and kept in the van for a long time and feeling anxious all the time, they did not listen to me the cuffs were very tight and I was getting more and more irate feeling more and more anxious and without my medication" **White British Male**

The bureaucracy to obtain medical care was highlighted by one cohort of women, who spoke of a form having to be filled in with several options asking them to tick which service they wished to access (GP, mental health, sexual health, and nurse). The women complained that they could not diagnose themselves until they saw someone. They just wanted to see a GP.

For foreign nationals and women born outside of the UK, there was a concern that their cultural and religious dietary needs were not being met. This is similar to the issues raised by men, and there was even an allusion to racism:

"I keep going to the doctor to have blood tests but they don't tell me what is wrong with me, they have taken so much blood from me and I am losing weight. One of the nurses said to me, ''you're coming to healthcare too much and I'm fed up of seeing your face and you're not a British citizen" **Black Caribbean Female**

Another offender complained of the lack of food provided as a diabetic, particularly when returning from hospital appointments in the early evening:

"When I came back from hospital there was no food for me and I am a diabetic I had to eat biscuits and sometimes the food is not very nice, I found a worm in my food once and I rang the bell, told the officer who told me to throw it away but I did not have any food" **British Pakistani Diabetic Female**

As with the male older population, women complained about the lack of dignity and respect. The key area where they felt this was lacking was during strip searches for suspected drug smuggling for example, or before and after visiting hospital for an appointment. One older female offender felt humiliated by the experience and undignified.

Access to GP's was also an issue raised by women and the delay in seeing a health professional.

"You need to know two months in advance you are going to be ill" **White Female Drug user**

That statement echoed the sense of frustration felt by the women collectively at the lack of appropriate and efficient access to primary care in their prison.

"My husband sent my prescription recorded delivery but still not getting my medication" **British Asian Female**

This latter issue of prison healthcare making contact with an offenders' home GP was raised by women more than men. The women felt that an easier, and quicker, process could be developed to ensure their medical records were readily available for healthcare staff, and medication provided more efficiently. Access to mental health and counselling was also raised by the women who felt that this was also a long process.

"I told them my first day I came in that I want to be assessed for mental health but haven't been yet, if I want to see the psychiatrist, its another form then the GP say's 'why do you want to see a psychiatrist?'" **White British Older Female**

Gender In Conclusion

Within the health pathway, police custody is an area of most adverse impact for generic and some specific healthcare needs. Primary care therefore is as vital in this setting as it is in prison to assess initial needs and undertake further consultation as required. Males complained less of primary healthcare than women, with females seeing their needs as complex and not specific to their gender. Specialist services such as drugs, alcohol treatment were felt to be inconsistent, and services for offenders (e.g. for long term conditions) were seen as being ignored. Work is required to develop appropriate models to more fully meet the health, diet and cultural needs of those with specific requirements, for example foreign national women.

Gender Reassignment

We have highlighted two case studies in this section of individuals diagnosed with *gender dysphoria*. This group of offenders is particularly vulnerable as a result of society's view of gender reassignment and perceptions of gender dysphoria. Isolation and exclusion will impact immensely on the health and well being of these individuals, especially whilst awaiting specialist medical support which can take a considerable amount of time. Perceptions were very dependent on the level of service and support received and both positive and negative feelings were expressed. Positive comments included:

"Mental health team have been great, they offered me support if I needed any, counselling to see or talk to anybody, there always around" **White male with gender dysphoria**

*"I asked to see a member of the health team and, I liked to see them, it was three months ago, so I suppose not". **White male with gender dysphoria who felt he was not getting the support he needed.***

"That would be fantastic, just to talk to someone, it feels like I'm the only person who's suffering in prison, it's like I have to keep quiet, and I feel as my problem is not important, and it impacts me mentally, like what's the point". **Respondent stating the positive nature of a self help group.**

However, the accounts of two offenders with gender dysphoria of their experiences with healthcare professionals make clear that access to treatment is a real issue. Their experience of primary care in prison was not always a pleasant one with judgments being made by professional healthcare staff, including those who felt their personal religious beliefs had been compromised by their healthcare duties. This impacted on the offender, adding to a sense of isolation and distress given the complex nature of their medical issues. An individual may be struggling with personal issues and not be aware of his or her condition of gender dysphoria until reaching prison. Identifying their condition and seeking support is crucial. It is important that they are seen objectively and professionally by healthcare staff.

"I asked the doctor for some cream for my face to stop the hair growth so quickly, cause I wear makeup and that in the cell, and also there's a shampoo you can buy to stop the thickening of the hair, Prior to coming on to hormone therapy, I've worked it up and I've researched it and it is an entitlement because gender dysphoria is under the NHS, the mental health act, anything under the NHS, if your entitled to it on the outside, you can have it in here, I've tried saying that to the doctor, and he laughs at me, says "but you are a man, what do you want all that for?", um he didn't do anything for me, sat and looked at me and giggled" **Respondent expresses concern over the professional response when seeking support and understanding of gender dysphoria related issues.**

Another commented:

"The GP's are very very difficult because in a situation like this, rather having to explain it every step of the way, I mean for me, I'd like to see regular GP I know in prison that is very difficult, but having to sit down and try and explain your situation to a new GP every time, it comes back to time, they haven't got the time to sit and listen and so you never get passed the first corner" **Respondent feels anxious over the lack of consistency in seeing the primary healthcare professional.**

Offenders highlighted their experience with healthcare from early inception, in not recognising their condition and how they were isolated from other offenders who do not understand their condition.

"*You don't really get, you don't talk to them, no one really talks to you like when you go to health care, you sit in a room about this big, and um you're locked in there about twenty of you. And one by one your called to see the doctor, it's quite uncomfortable to say the least, you don't feel like your with a normal GP, I'm quite a chatty person, I'll sit and talk to anyone, but even when I sit there its horrible, they just sit and look at you*" **Respondent states his opinion when asked about support from nursing staff.**

Secondary care also arose as an important issue, and the time lapse to access secondary mental health services or specialist psychiatric services related to gender dysphoria recognition was slow.

"I suppose that, hard part it all, is time, you know, I'm 30, I wana stop my body changing, I got to wait seven or eight months to see a gender specialists and to officially start my journey. By that time I'm 31 um, and I got to see two of those, so next time round I'll be 32 and, everything just seems, everything takes so long, and I wana, for me I wana stop this now. I wana almost put my body on hold, so, stop where you are but you can't do that. So, all the time there taking, my body's changing, growing and that distresses me even more it's, I don't think it's the people who don't want to help, it's like, in a situation like this there are a certain number of specialists and, the one thing they can improve that is shorten the time we have to wait". ***Respondent expresses fear of time passing whilst he awaits progress on his gender reassignment****.*

Counselling and support seems to be a crucial area required from mental health providers and commissioners, together with external support groups for offenders with gender dysphoria can identity with.

Gender Dysphoria In Conclusion

There was a lack of support from healthcare with those interviewed feeling that they were subjected to mockery by some healthcare professionals (GP's, Nurses), while this is not always the case, there are inconsistencies over how individuals with gender dysphoria are treated in primary care, Mental health services and access to psychiatry is also seen as an area for development for this group, Access to secondary consultations and appointments and the time delay were a factor for some as it directly related to their gender reassignment. There was a need for more specialist support in this area reinforced by appropriate support groups and counselling. The religious beliefs and judgements of staff, whether prison or healthcare were also seen as having an adverse impact on health and well being.

Additional experiences of probation

A number of respondents spoke of their experience with the probation service, reflecting on their race, gender, sexual orientation, religion or belief, age and gender reassignment status. These experiences seemed to vary dependent upon the probation officer assigned to them. Some developed good relationships with such professionals, whilst others felt they did not meet their specific support needs or lacked understanding of their concerns.

"I don't think my probation officer was any good not always easy to get hold of or talk to" **Black British Offender**

"They don't do much for you just want to get their paperwork sorted, didn't help me" **White British female offender**

Positive experiences were also highlighted:

"He listened to what I had to say and helped me a lot by just talking through some of the issues I had" **White British Male Offender**

Similar to experiences of other agencies there was a need for more joint up thinking on helping offenders with specific support needs as in the case of this individual who felt his family was important in his emotional well being:

"Prison should give info to probation on the inside and outside. More links should be formed between families as well" **Young white British male.**

Within the context of the seven strands, many felt that there was a lack of understanding of their specific needs related to equality issues. For some, these never featured in discussions with probation teams, leaving those involved feeling undervalued as part of monitoring process. This may be an area where training and understanding of equality issues become more prominent and explicit within offender management. Active engagement and dialogue with offenders who have multiple identities related to their gender, sexuality, race, religion and so forth to comprehend the broad range of needs, requires active encouragement by senior managers.

Next Steps

An Equality Steering Group, reporting to the cross-departmental Health and Criminal Justice Programme Board via the National Advisory Group, will be established under the auspices of Offender Health to monitor, evaluate and co-ordinate delivery of the equality action plan set out below, and ensure equality outcomes are mainstreamed within policy development in consultation with other government departments as required.

Some areas of work are already progressing on this agenda and should be noted, whilst others will require further work and embedding within core areas of delivery, both on a national and regional basis. Additional support and guidance will be developed to support national and regional stakeholders in the undertaking of EIAs in the health and criminal justice field.

The concept of equality is integral to the delivery plan itself, and the equality strands reflected in its broad vision and deliverables. Building on this initial, overarching, equality impact assessment , each deliverable (or set of, where appropriate) within the delivery plan will be subject to a full equality impact screening and assessment, led by the appropriate policy lead within Offender Health in liaison with other Government Departments where appropriate. The equality action plan should be read with this in mind. Note that the latter does not reproduce all deliverables from the delivery plan.

As the delivery plan proceeds to implementation, it is important that' policy leads, commissioners and providers maintain effective dialogue with key stakeholder groups including offenders and their families. Support groups and third sector organisations are also valuable in highlighting issues faced by this group. Independent statutory inspection bodies (e.g. Her Majesty's Inspectorate of Prisons[30]) and, in prisons, Independent Monitoring Board[31] reports also provide useful information and evidence of the needs of offenders with up to date evidence and audits, including healthcare. Making Experiences Count,[32] aiming to reform health and social care complaints procedures, is also a key policy document signposting how the views of offenders should be acted upon to improve services. Patient and Public involvement Leads, using the Patient Advisory Liaison Service[33], have an important role to ensure the concerns of offenders and ex-offenders are captured as part of an overall service improvement methodology. lastly, the EIA in itself is an extremely valuable tool for ensuring concerns and user experiences are captured, analysed and rectified.

[30] http://www.justice.gov.uk/inspectorates/hmi-prisons/ for further information.
[31] http://www.imb.gov.uk/becoming-member/ for further information.
[32] http://www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/MakingExperiencesCount/index.htm
[33] http://www.pals.nhs.uk/

The routine capturing of data on the seven equality strands is also necessary to build a more comprehensive picture of who accesses services and where. The equality action plan considers how this can be achieved via current initiatives, including development of information management and technology and performance indicators, alongside the work of the Offender Health Research Network. For all agencies (i.e. NHS, Police, Prisons, Probation and the Courts), data on the experiences of gay and lesbian groups, gender dysphoria individuals, people with multiple identities, amongst others needs to be captured, both at a qualitative and quantitative level.

Equality Action Plan

This section matches equality actions resulting from this impact assessment against relevant deliverables, from the delivery plan indicating how they can be adopted at implementation.

Objective 2: Working in Partnership

To support and enhance the joining up of services by improving partnership working between criminal justice, health, and social care organisations at all levels, enabling effective and appropriate health, social care and criminal justice outcomes at every stage in the criminal justice process.

Relevant Deliverable(s) from Delivery Plan	Equality Action	Outcomes /benefits	Lead workstream	Timescale
Equity of Access - Equality Impact Assessments	Regional partners to consider a robust and standardised framework that all organisations involved in the implementation of offender health policy can work within. This should cover joint working, protocols between organisations and equality leads, and core equality competencies for specialist equality roles. The principles of freedom, respect, equality, dignity and autonomy need to be embedded into this approach.	• Comparable EIA standards across organisation. • Mitigation of 'consultation fatigue' via stakeholder groups. • A credible framework and workforce who can raise confidence in services for socially excluded groups.	Equality Steering Group	April 2010, with annual review.

Working with Connecting for Health, we will ensure optimal use of clinical IT systems to improve and assure the quality of clinical care in the CJS and provide information in support of public health and commissioning and scope what the system requirement options might be for this pathway approach, by October 2010.	A standardised equality monitoring system needs to be integrated into this area of work that can also disaggregate data on access to clinical services provided to groups within the seven strands. This approach could support monitoring of equitable access to services.	Data collection across organisations is robust and analysed to assess trends and gaps using standard data set.	Information management and Technology	October 2010
Regional Offender Health Boards will develop and implement a training strategy and be monitored on this	Regional partners to ensure joint training covers impact and equality proofing of policy and services, and that this is also built into organisational training strategies. This training should be subject to an annual evaluation with a strong user involvement focus. The principles of freedom, respect, equality, dignity and autonomy should be embedded into this approach.	A standardised and credible training programme that is robust to external and user scrutiny.	Cross-cutting	April 2010
We will work to understand and develop training needs for police officers, police civilian staff and healthcare professionals to ensure that detainees, vulnerable through	The needs of different groups based on the seven strands of equality need to be an essential element of this approach (i.e. an understanding of different health scenarios based on gender, race, disability, sexual	• Increased awareness amongst agencies and staff of health issues for	Cross-cutting	April 2011

mental ill health, physical ill health or social considerations, have access to competent practitioners by 2011 (Bradley Recommendation 16) We will work jointly with the National Police Improvement Agency (NPIA) and key stakeholders on understanding training needs for appropriate adults and other third parties coming into custody by April 2011 (Bradley Recommendation 9)	orientation, age, gender reassignment, religion or belief). This should build on work currently in progress with the NPIA to develop a broader equalities set of scenarios reflecting the issues and needs of specific groups. Users and specialists within the equality field should also be fully involved and consulted.	socially excluded groups, and within different settings. • Joint working will facilitate cross sector understanding of health and social care issues related to diverse population groups.		

Objective 3: Improving capacity and capability

To contribute to the development of an informed and effective workforce to deliver services for offenders with health and social care needs, making sure they are able to work confidently across organisational boundaries, by equipping them with the right skills and knowledge to share information and take co-ordinated action that supports continuity of care.

Relevant Deliverable(s) from Delivery Plan	Equality Action	Benefits/Outcomes	Lead Workstream	Timescale
We will provide guidance for PCT offender commissioning leads that puts the specific commissioning issues within a WCC context. It will bring the	Guidance should consider equitable commissioning issues in relation to health inequalities and epidemiology of offender population groups within the seven strands of equality. PSA's on	The needs of diverse groups within the seven strands are met in the procurement of	Commissioning	April 2010

priorities including PSAs and best practice into a single usable document by April 2010 (Bradley Recommendation 77)	tacking health inequalities and tackling discrimination are essential levers for this deliverable. Local commissioners should be encouraged to undertake local EIA's to support implementation that relates to the offender population type in their community. This should build on guidance already developed HSCCJP SE on equitable commissioning related to the EIA process and the commissioning cycle.	services.		
The benefits will be reflected through improved performance against key performance indicators. The "framework models" will conform fully to the Quality Outcomes Framework and progress will be monitored via the mainstream processes in place in the wider community. The implementation of Primary Care IT systems will enable the transition to effective contract performance management.	The performance indicator on equality and diversity within the Prison Health Performance and Quality Indicators should be enhanced to ensure effective mainstreaming of equality issues in services as well as in the QOF at a local level. The FREDA principles should be considered.	Both qualitative and quantitative elements are captured within all seven strands of equality with better outcomes reflected in the indicators.	Information management and technology / Commissioning	April 2010

We will work with regional offender health structures and local PCT commissioners to ensure that the health needs of residents in approved premises are identified and included in PCT/Local Authority Joint Strategic Needs Assessments and in PCTs local planning arrangements, linking in with the core World Class Commissioning work throughout 2009 and 2010 (Bradley Recommendation 77)	Full consideration to be taken of the health needs of diverse groups within approved premises. E (JSNA) epidemiology highlighted and fed into the JSNA.	The needs of diverse groups are met.	Commissioning	April 2010
We will ensure that the care of offenders is reflected in the mainstream of DH social exclusion programmes. We are developing a report to consider a new approach to primary care for socially excluded people, and developing commissioning guidance for primary care for the socially excluded. Both reporting by early 2010.	Consideration should be taken of diverse range and needs of the offender population and disparities between access to services for offender population groups based on their race, gender, disability, gender reassignment, age, sexual orientation and religion or belief, should be investigated. This should be built into the commissioning guidance.	The disparities are reduced between different socially excluded groups and reflected in public health programmes.	Primary and Social care with DH Social Exclusion Unit	Spring 2010
We will prepare, jointly with	The epidemiology of offender groups	Equality issues are	Commissioning	Spring 2010

the National Directors for Primary Care and Coronary Artery Disease, a commissioning framework for the identification and clinical management of coronary heart disease for people in prison	within the context of race, gender, disability, sexual orientation, gender reassignment, age, religion or belief should be identified within this commissioning framework.	embedded within the framework and are acted upon.		
Developing Providers				
We are committed to working more effectively with the private and third sectors as potential providers of services. As a first step in engaging and involving these organisations in the development of the government's action to respond to this Plan, we are developing a picture of current activity and ideas for developing services. (Bradley recommendation 42)	This work should ensure that third sector and independent organisations working with offender populations in the context of the seven strands are fully identified within this policy area. The NHS portal MOSIAC[34] has developed good practice related to procurement and equality issues and will be a useful resource to support delivery.	The process of procurement is open and fair for all to take part in particularly smaller third sector organisations.	Commissioning	2010
Over the next six months,	To be proactive in engaging with the	Increases plurality	Commissioning	April 2010

[34] http://www.mosaic.nhs.uk/ 2*The Mosaic project team have worked with key stakeholders in the NHS supply-chain to promote equality in and through procurement. Funded by the Department of Health, it works with staff, suppliers and interested parties to align efficiency and equality goals" (quote from website).*

working in partnership with the sectors, we will highlight innovative work, hold learning events to encourage other organisations to offer similar services, and raise the profile of these organisations and the services they provide with commissioners.	diverse range of providers and potential providers that meet specialist needs of groups within the context of the seven strands of equality, pending a full EIA.	and diversity of supplier base providing specialist and appropriate services to diverse groups. .		
Measuring Success				
Further development of the Prison Health Performance Indicators[35] (DH 2007) to, where possible, include assessment of quality across the offender pathway By December 2010.	The performance indicator on equality and diversity within the Prison Health Performance and Quality Indicators should be enhanced to ensure effective mainstreaming of equality issues in services. Assessment should involve user feedback.	Provide better evidence of equality of opportunity for all offenders accessing health and social care services appropriate to their needs.	Information Management and Technology	December 2010
The NHS non-mandatory standard mental health contract includes reference to specific offender health issues against which PCTs are expected to make progress. By April 2011	The standard contract should contain references to equality across the seven strands, pending a full EIA, with a human rights element.	Equalities are embedded within the contract and can be monitored accordingly for delivery.	Mental Health and NOMS	April 2011

[35] Reference and link to indicators

We will promote the importance of patient and public involvement of offenders in the development and design of services, publishing guidance to prisons on implementing Patient Advice and Liaison Services (PALS) (Bradley Recommendation 80)	Guidance should proactively consider diverse groups representing the seven strands of equality and advocate user involvement in the development of services. Communication and support needs to be available as well as advocacy.	The views of diverse and socially excluded groups are heard and not those of the most vocal and avoids gatekeepers.	Mental Health and NOMS	November 2009
In the longer-term, our aim is to integrate offender health into the Quality and Outcomes Framework (QOF) used to monitor mainstream primary care services	To ensure equality elements are built into this process to monitor access to socially excluded/diverse groups, pending a full EIA.	Monitoring of access to services is related to the seven strands of equality.	Primary and Social care	Post 2011
Workforce Development				
We will work with probation to evaluate the current suicide and self harm training in approved premises and recommend a best practice model to achieve consistency of approach by September 2010 (Bradley	Equality proofing should be considered in the evaluation of this training to address any gaps in knowledge and understanding related to specific groups based on the seven strands of equality including issues related to multiple identities.	Discrepancies related to specific groups are investigated and acted upon.	Cross-cutting	September 2010

Recommendation 21)				
We will develop and implement training and education plan for all front-line staff in NOMS, the NHS and Social Care agencies working with personality disordered offenders. From April 2010 We will support the development of the CJS primary care clinical workforce achieved by working with the representative and professional bodies. An MSc in primary care in secure environments is being developed. To commence in September 2010.	To ensure the training and education plan, and development activities including MSc, consider equality issues and differences between some diagnoses and individual identity definition (e.g. gender dysphoria may wrongly be diagnosed as a personality disorder). Caution is advisable in such complex areas. It is also advisable to embed a Human Rights and empowerment model within this deliverable.	A better understanding and awareness of individuals and epidemiology related to the seven strands of equality amongst the workforce, ensuring the equality issues are included at the heart of service provision.	Cross-cutting	April 2010
Risk Assessment				
We will therefore issue, by Autumn 2010, joint guidance that supports comprehensive assessments by all those agencies that come into contact with offenders with	Guidance should consider equality issues, and embed equality proofing for fairness and appropriateness, pending a full EIA.	Adverse impact is identified and addressed in compliance with statutory requirements.	Mental Health and NOMS	Autumn 2010

mental health problems, providing a shared understanding of the entirety of what needs to be included, e.g. risk to public protection as well as health and wider health determinant needs. This will include: • a common language to underpin the assessment process that also facilitates communication across the CJS and health; • A standardised approach to assessment, with a CJS/NHS protocol on the specified information that, as a minimum, will need to be shared, and which should form part of mental health or risk assessments. This protocol will also support the use and development of other more specific assessments, e.g. OASys, MAPPA, [anything in the NHS]				

• arrangements for training staff in the CJS and the NHS to support the above goals				
Research and Evidence Based Interventions				
Continue to develop the Offender Health Research Network and commission research reviews and specific research projects to underpin and develop the evidence for the work in this Plan. Research into the role of prosecutors and their decision-making in cases involving mentally disordered offenders and offenders with learning disabilities. The research will also look at issues around information sharing in such cases between the CPS and partner agencies.	To ensure that the activity of the health research network is fully inclusive of the needs of groups within the seven strands, including representation from researchers from diverse backgrounds as well as those working specifically with groups in the context of the seven equality strands. Research into areas within the seven strands should be undertaken, particularly where gaps are evident as illustrated within the literature review. This work should addressing disparities based on equality strands including human rights and 'FREiDA'. DN: indicate gaps	The network is representative of all strands of equality and promotes equality of opportunity in both its ethos and delivery of research. Research evidence related to the seven strands will assist in addressing any key issues and gaps related to the specific equality groups.	Public and Physical Health	Ongoing

Objective 4: Equity of access to services

To ensure that all offenders, irrespective of race, gender, disability, age, sexual orientation, religion, or belief, will secure the same access to health and social care services, appropriate to their needs and in line with standards set for the rest of the population.

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
We commit fully to ensuring that full equality impact assessments are undertaken for each strand of work that we have set out in this delivery plan We will aim to meet the needs of socially excluded groups based on race, gender, disability, sexual orientation, age, religion or belief by utilizing a robust equality impact process that addresses any adverse impact and improves access to services for disadvantaged groups.	Work towards a consistent and robust EIA process across the agencies representing the health, social care and criminal justice pathways. This includes proactive engagement with offenders and their experiences as recipients of health and social care services within the CJS. This model should enshrine the FREiDA and Human Rights approach to promote wider equity of opportunity.	Standardised and credible process that makes a difference by approach and outcome and can be evaluated by users.	Equality Steering Group	See specific deliverables.
We will develop the principles and learning from Count Me In for the rest of the pathway by	To apply Prison Census data assess disparities in accessing mental health services based	Inequalities related to the seven strands are addressed on a	Equality Steering Group	April 2011

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
April 2011	on ethnicity. This should be coupled with clear local action plans by PCT's to address under or over representation of the BME population in mental health services. This should build and develop on the Delivering Race Equality programme's shared capabilities and race equality cultural competencies for health and criminal justice.	gradual basis starting with race equality as set out in the learning from Delivering Race Equality (DRE).		
The initial evaluation of the pilot schemes to provide community mental health services for veterans will be available before the end of this calendar year and the final version in the spring of 2010. Our expectation is that all mental health services will make special provision for veterans during 2010/2011.	These pilot schemes should address the equalities agenda in relation to the needs of veterans representing the seven strands of equality, who may require appropriate and sensitive services to meet their specific needs, pending a full EIA.	The needs of the diverse range of veterans are met and specific to their individual needs.	Mental Health and NOMs	2010/2011
Primary Care				
Working with regional partners	Pending a full EIA, to support the development of appropriate	The potential for discrimination is	Primary and Social Care	Ongoing

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
we will drive the development of a comprehensive primary care service across the criminal justice pathway incorporating the key features of services experienced in the community	and responsive services for those with multiple identities and specific needs.	eliminated and statutory duties related to equalities are met.		
Mental Health				
We will develop a robust care pathway approach in relation to mental health and how this will impact at all points in the criminal justice pathway, supporting early intervention. We will strengthen the process whereby information is readily available about an individual's mental health or learning disability needs, to allow decisions to be made where appropriate for non-custodial or tailored sentences with access to health services and specialist supervision.	The care pathway approach should consider the needs of offenders within the context of the seven strands of equality due to potential for specific needs related to diagnosis and treatment. The roles and scope of work undertaken by community development workers (CDW's) should be reviewed in line with this and wider criminal justice work, pending a full EIA.	To promote equality of opportunity and meet statutory duties under the equalities legislation.	Mental health and NOMs	Ongoing
Secure Services				

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
We will produce guidance and associated training materials on relational security by December 2009.	Guidance and training should fully consider equality issues in relation to tackling direct and indirect discrimination with due regard for the seven strands of equality and 'FREiDA' principles.	The needs of the diverse groups are addressed as a core component of the guidance and training.	Mental Health and NOMs	December 2009
Drug Services				
Professor Lord Kamlesh Patel has been asked by Ministers to Chair and establish the Prison Drug Treatment Strategy Review Group to consider the funding, commissioning, performance management and delivery of services within prisons, and to explore and provide recommendations on how to improve the continuity of care of drug-using offenders leaving prison. This is a two-year review from April 2009 to March 2011 – the first key milestone has been the production of an interim report to Ministers in October 2009.	A robust EIA process needs to be aligned to this area of work to ensure services meet the needs of the diverse groups and identifies any adverse impact to future services in regard to the seven strands of equality should be considered.	The needs of the diverse groups of offenders are met and sensitive services developed according to individual needs.	Drugs	March 2011

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
Alcohol Services				
We will progress towards a provision of alcohol treatment for a minimum of 15% of offenders identified as potentially alcohol dependent across all regions. Progress in this area will also be monitored via the NOMS OASys processes. We will provide further support through the Alcohol Improvement Programme by: • promoting policy, evidence and example of promising practice through the offender section of the Alcohol Learning Centre • the Alcohol National Support Team will highlight offender issues in all its alcohol visits – the Team visits 18 PCTs each year focusing on the	Treatment services need to consider the needs of offenders within the seven strands of equality, who may not immediately present themselves as potentially alcohol dependent users. The alcohol improvement programme will need to reflect the equality dimension in its action plans and new services should be equality proofed. This also applies to the Alcohol National Support Team, pending a full EIA.	The needs of individuals within the equality groups are met and responsive services developed to meet their specific needs. Services are accessible to all and appropriate to their individual identities.	Alcohol	TBC

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
PCTs with the highest rates of alcohol related hospital admissions				
Physical and Public Health				
A suite of health promotion and harm reduction initiatives designed to reduce blood-borne viruses (BBVs) in prison. This work ties in with the work on drug treatment i.e. the integrated drug treatment system. An OH commissioned evaluation by Stirling University of the Department of Health's Disease Prevention and Health Promotion Policies and Programme Initiatives for Tackling BBVs in prisons in England & Wales.	This should take into account the epidemiology related to groups within the seven strands of equality and consider an EIA to identify any gaps that require addressing. All initiatives need to be sensitive to specific needs across the seven strands of equality.	The needs of diverse groups are met related to specific evidence of epidemiology and responsive solutions. The evaluation will highlight any gaps related to the seven strands and the needs of diverse groups.	Physical and Public Health	March 2010
Publish research reporting on a case control study of self inflicted deaths in prison as conducted by	Self inflicted death reporting and analysis should include	Ability to analyse any gaps related to the seven strands and the needs of	Public and Physical Health	January 2010 / Ongoing

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
the National Confidential Inquiry for Suicides and Homicides Create a template and database to analyse all Prison Probation Ombudsman reports of deaths in prison. The database includes information on the physical and mental health prior to death, treatment provided and PPO recommendations; the PPO will undertake data analysis and provide regular reports on epidemiology and aspects of health care.	consideration of any trends in respect to the seven strands of equality and equality monitoring, pending a full EIA.	diverse groups.		
Social Care				
We will implement an agreed national plan for the management of older prisoners and disabled prisoners both in prison and on release into the community by March 2011.	Work should consider possible multiple identities in respect to the seven strands, pending a full EIA.	Improved personalization of services and individual support.	Primary Care	March 2011

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
We will complete and evaluate the Isle of Wight pilot on care pathways for older prisoners, by March 2010. This will inform national implementation of a standard national pathway across all prisons from March 2010.	National implementation of this pathway should take into account the seven strands of equality pending a full and robust EIA as part of this development.	To meet statutory duties and promote equality of opportunity and access to appropriate and responsive services tailored to individual needs.	Primary care	March 2010

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
We will develop a normalised model of social care delivery for prisoners based on an agreed understanding of roles and responsibilities with NOMS, Local Authorities and NHS Commissioners by September 2010.	This model of social care should be Equality Impact Assessed in line with the statutory requirements.	Meet statutory obligations	Primary and Social Care	September 2010
Working with NOMS on a management programme to place prisoners in the most appropriate locations by December 2009.	Determination of placements in appropriate locations will need to assess individuals with due regard to the seven strands of equality to ensure reasonable adjustments are made and other needs taken into account.	Promote equality of opportunity.	Mental Health and NOMS	December 2009

Delivery Plan Deliverables	Equality Action	Outcome/Benefit	Lead Workstream	Timescale
Developing NHS and Local Authority services for "groupings" of older or disabled prisoners by June 2010.	Subject to and pending a full EIA process to ensure specific group needs are met.	Meet Statutory Obligations	Primary and Social Care	June 2010

Objective 5: Improving pathways and continuity of care

To develop care pathways that enhances health and social care provision and contributes to the delivery of justice. Pathways will focus on assessment and intervention at as early a stage as possible, and will support improved risk management and continuity of care. This will contribute to improved health and well-being of offenders.

Delivery Plan Deliverables	Equality Action	Outcomes/Benefits	Lead Workstream	By when?
The Police and Crown Prosecution Service				
We will introduce a national template and guidance on the application and use of section 135 of the Mental Health Act by October 2010 We will introduce a national template and guidance on the	The national template and guidance should fully consider the seven strands of equality. The guidance should set out some of the key issues related to different groups to help inform staff in health and the criminal justice system, pending a full EIA	Meet statutory duties and promote equality of opportunity and eliminate any potential for discrimination.	Police	October 2010

application of section 136 of the Mental Health Act by October 2010	process.			
Courts				
We will reduce the current delay in producing court psychiatric reports. We will support implementation of service level agreements between PCTs and HMCS for provision of court psychiatric reports. We will devise a national template and issue guidance by April 2010, supporting delivery by April 2011. (Bradley recommendation 23)	Potential for adverse impact in equality terms, as individuals within the seven groups may present different episodes, Appropriate models of assessment which fully consider the needs of offenders across the seven strands of equality should be developed, pending a full EIA.	Meet statutory duties and promote equity of access.	Courts	April 2010
We will ensure that processes and capacity allow the use of community orders with mental health treatment requirements in all appropriate cases. We will do this by considering the need for further research regarding reported low utilisation of the mental health treatment requirement as a sentencing option, by April 2010.	Work should be undertaken to assess whether the use of community orders is over represented amongst certain groups within the seven strands of equality, and consideration given to what additional research may be required to understand disproportionality in this area, pending a full EIA.	Eliminate the potential for discrimination both direct and indirect in line with statutory obligations.	Courts / NOMS	April 2010
We will issue guidance to enable	Pending a full EIA, due regard is	Promote equity of	NOMS	September

probation to better access health service providers, in order to ensure that offenders' mental health and learning disability needs are addressed within pre-sentence reports and community orders, by September 2010	paid to the seven strands of equality and addressed in the guidance and addressed within pre-sentencing reports and community orders. Equality monitoring is aligned to this process to capture data and assess any gaps in service provision.	access.		2010
Liaison and Diversion				
We will promote and stimulate the development of liaison and diversion services through: • Detailing the benefits of liaison and diversion services within New Horizons[36] which is due to be published later this year and embed this in PCT commissioning plans by Spring 2011 • Providing a clear cut economic case for the financial and health impact of liaison and diversion services	Pending a full EIA, court diversion and liaison services should be assessed for appropriateness in terms of the needs of diverse groups across the seven strands of equality. This should include equality monitoring of clients to assess under-representation in liaison and diversion schemes as well as developing appropriate referral services to meet specific needs. Issues related to groups not accessing such services should also be considered to address any adverse impact in commissioning plans. Use of existing resources such as	The needs of diverse groups are met and any potential for discrimination is eliminated in line with statutory duties. The use of CDW's would be resource neutral and have the benefit of understanding issues related to discrimination and access.	Courts	Spring 2011

[36] Reference New Horizons and link

on other mental health and community based LD services by Summer 2010 • Model the financial benefits of liaison and diversion services for local authorities, prisons, probation and the police by Autumn 2010 • Provide guidance on the objectives, scope, functions and outcomes of liaison and diversion services by December 2010 • Develop systems to facilitate the collaborative commissioning that will lead to joined up liaison and diversion services by December 2010 • Provide additional information and tools for commissioners by December 2010 • Work with existing schemes to develop a series of assessment proforma and a	community development workers (CDW's) to support liaison and diversion schemes should also be considered as part of the wider equality agenda. This role The role of CDW's should be considered to support the needs of diverse groups, taking into account regional pilot work undertaken in this area.			

minimum data set for use by liaison and diversion service providers by December 2010 • Agree data collection / sharing processes for those involved in the delivery of liaison and diversion services by December 2010 • Revisit the potential and mechanisms for pooling budgets at a local level by Spring 2011 These actions should enable local commissioners to include the development of the services in their future plans and for providers to have models of best practice for their delivery.				
Prisons and Probation				
We will improve transfer between prison and secure hospital. We will work to establish a national standard for the transfer of mentally ill prisoners under sections 47 and 48 of the Mental	The national standard should address issues related to the under or over representation of specific groups based on the equality strands, being transferred or not, including the	Identify any gaps or discrepancies within the context of the seven strands and eliminate the potential for	Mental Health and NOMS	April 2010

Health Act 1983. We will work with NOMS, government agencies and the NHS to address the structural, process and service changes required to underpin delivery by April 2010 (Bradley recommendation 43)	lengths between different population groups, pending a full EIA. The Prison Census annual audit can highlight discrepancies in respect to transfer related to diverse group and should be considered.	discrimination.		
Undertake an evaluation of the existing enhanced mental health SLAs for approved premises in relation to effectiveness, value for money and recommend future models to meet mental health	The evaluation should take into account equality issues and whether these have been met in the SLA's to promote equality of access and meet the statutory equality duties.	Promote equality of opportunity and support anti-discriminatory practice.	Mental Health and NOMS	August 2010

needs by August 2010 (Bradley recommendation 20)				
Working with NOMS scope and develop a model rehabilitation service for individuals with mental health or learning disability problems, who are not subject to supervision from probation on release, initial report completed by July 2010	The model to be developed should address issues related to multiple identities of offenders and ensure the model is compliant with equality legislation.	Meet the needs of diverse offender population groups.	Mental Health and NOMS	July 2010
Using existing evidence undertake a review of the current health reception screen process, strengthening the areas of screening for mental health and learning disability and have a new screen in place by 2011	Pending a full EIA, to reduce any adverse impact on groups within the context of the seven strands of equality. Different population groups present a range of mental health issues that may be specific to their race, gender, disability and so forth, these need to be considered in any screening programme of work.	Meet statutory obligations.	Primary Care / Mental Health	2011
Human Rights	To investigate the implementation of the principles enshrined with the Human Rights	Policy and implementation is set with a Freedom,		Ongoing

	Act and those of Freedom, Respect, Equality, Dignity and autonomy are embedded within the ethos and practical implementation of the delivery plan that promotes an empowerment and rights model in line with the current Department of Health ethos.	respect, equality, dignity and autonomy based set of principles.		

Key	
EIA	Equality Impact Assessment
FRED/FREiDA	Freedom, Respect, Equality, Dignity and autonomy (see Human Rights Annex in EIA Report)
HSCCJP	Health and Social Care in Criminal Justice Programme
Seven Strands of Equality	Race, Gender, Disability, Sexual Orientation, Religion or belief, Gender Reassignment, Gender, Age. The 7+1 has also been referred to and relates to Human Rights as the plus one element.

For the record

Name of person completing the EIA:	Fiona Pearson (DH) Manawar Jan-Khan (HSCCJP)
Date EIA completed:	23 October 2009
Name of Director General endorsing the EIA:	David Behan
Date EIA endorsed:	X

Annex A: Consultation matrix

Establishment	Race	Gender	Gender Reassignment	Disability	Religion or Belief	Age	Sexual Orientation	Details
HMYOI Aylesbury	✓				✓	✓		**Male:** 5 Black African Caribbean (4 Muslim) - 1 Eastern European (Catholic) 1 Mixed Race - 3 White British (Church of England) - 1 Irish (Catholic)
HMP Milton Keynes	✓				✓			**Male:** 5 White British (Church of England) - 3 White British (Catholic) - 1 British Indian (Hindu) - 1 Irish (Catholic)
HMYOI Feltham	✓				✓	✓		**Male:** 5 British Asian (Muslim)
HMP Huntercombe	✓				✓	✓		**Male:** 5 White British (Church of England) - 1 Gypsy and Traveller (Catholic) - 1 Black British (No Religion)
Josephine Butler Unit	✓	✓			✓			**Female:** 3 White British (Catholic) - 2 White British (Church of England) - 1 British Asian (Muslim)
HMP Winchester	✓	✓	✓	✓	✓		✓	**Male/Female:** 1 Black British Disabled (Baptist) - 1 White British Disabled (No Religion) - 1 Transwoman Lesbian (Pagan) - 1 Straight Female with Gender Dysphoria (No Religion)
HMP Winchester				✓		✓		**Male (Older Prisoners):** 1 White British (No Religion) - 2 White British Disabled (No Religion) - 1 Mixed Race British (No Religion)
HMP Styal	✓	✓			✓	✓		**Female:** 2 White British (Church of England) - 1 Older Woman - 1 Jamaican (Baptist) - 1 Pakistani (Muslim)
Moss Side Community Centre	✓	✓			✓			**Male/Female:** 1 Black Caribbean Male (Church of England) - 1 Black British Male (No Religion) - 1 Black British Male (No Religion) - 1 White British Male (Church of England) - 3 Black British Women (Baptist)
Hideway Youth Project	✓	✓			✓	✓		**Male/Female:** Group of Young People (16-17)
Trinity Youth Project	✓	✓			✓	✓		**Male/Female:** Group of Young People (15-17)
Biographies		✓						**Female:** White British
		✓						**Female:** White British
				✓				**Male:** White British Disabled
				✓				**Male:** White British Disabled
		✓						**Male:** White Other
				✓				**Male:** White British Disabled
		✓						**Male:** White British
	✓	✓				✓		**Female:** Older Pakistani (Muslim)
	✓	✓			✓			**Male:** Black British (Baptist)
				✓		✓		**Male:** Young White British Disabled

Annex B: Review by Human Rights Specialist of Biographies and One-to-One interviews

Dr. Theo Gavrielides
Race on the Agenda

General comment
I was asked to review seventeen transcripts that included data from one to one interviews and group discussions with health care service users while in custody (juvenile and adult institutions). The data was collected in 2008 2009 and all cases seem to date post Human Rights Act.

While reviewing the transcripts, I paid attention to any evidence that may raise concerns of human rights breaches. Often, customer service delivery standards, equality standards and human rights are blurred, and the distinction is not easily identified. One of the key differences between human rights standards and other rights or equality law requirements is that they apply to everyone. This includes inmates and foreign nationals. However, it is worth noting that most human rights are qualified irrespective of individual status. Individuals who break the law willingly compromise some of their rights and liberties, the most obvious one being their liberty of movement. However, there are still human rights standards that cannot be dropped below and this is the area that I focused my attention on.
A caveat that it is worth pointing out is that from the transcripts alone, it is often impossible to check the truthfulness of most of these cases. The facts are one sided as the public authority was not given the opportunity to comment. Therefore, the findings and conclusions are based only on the available data. I devised the findings into four main categories:

1. Possible human rights breaches

In the document titled “General health care in the community”, under religion and food, there was evidence that may raise concerns of a possible breach of Article 9 “Freedom of thought, conscience and religion”. Paragraph 9.2 qualifies the right, but any limitation has to be balanced (principle of proportionality). I advise that case law is consulted to see if there is any precedent where failure by a public authority to make dietary adjustments was found to be in breach. For policy purposes, it is worth looking at the implications of any necessary adjustments not just for Muslims but also for any other religion that may require similar reasonable steps.

Separate but similar is the issue of providing enough food (not just the right food) during a religious period (in this case Ramadan). Failure to do so may

raise concerns under Article 2 “Right to life” especially if the inmate is suffering from a known health problem. According to jurisprudence, public authorities have a positive obligation not only to refrain from any action that could lead to someone losing their lives (or deteriorating their health), but also to take any reasonable proactive steps to protect them. If due care is not given to make reasonable adjustments during religious periods and a health or life issue arises, the public authority may be found to be in breach. The Article is qualified and it maybe the case that the public authority has a justified reason for this exception. However, from the evidence presented, I do not see any exceptions that are applicable here. The same issue was raised in Biography 7.

In the same document under religious practices, there was evidence to suggest that Article 9 might be in breach. It is not sufficient to provide space and time for a Muslim to pray but also ensure that they can pray without interferences. By walking in front of them or by not removing shoes while in the prayer room may lead to a possible breach that is not qualified. This is a reasonable adjustment that can easily be made. Exceptions are acceptable but not a complete disregard of this entitlement.

Joseph Butler Unit: I advise that the blanket policy not to allow family members to visit if they have a criminal record is looked at in more detail. There might be case law from the European Court of Human Rights where this was found to be in breach of Article 8 “Right to respect for private and family life”. The right is not absolute. Paragraph two qualifies it and it might be the case that “in the interest of public safety” the right is here limited. However, the court rarely has accepted blanket policies. Case law to be looked at more carefully.

Winchester prison number 1 and 2: From the transcripts there seem to be enough evidence to show that the public authority has taken enough reasonable steps to respect the individual’s private life, which includes their sexual orientation and preferred gender. The only area that might raise concern (but was not explored in detail by the research) was the transfer of the inmate to a women’s institution once in a different gender. If kept in the same facility this could lead to a breach of Article 8 or even 2 and 3.

Winchester Prison, number 4: Although most of the concerns here should be looked at in the context of DDA, there is one issue that could fall under the human rights remit. This relates to the fact that the inmate did not have a shower for 9 days due to the authority’s failure to make reasonable adjustments. There is enough evidence for a case under Article 3 “Prohibition of inhuman or degrading treatment”. The article is absolute. Josephine Butler Unit: Lack of access to family (in this case a child) due to distance might rise to family life”. The transcript does make a safe conclusion though. As under paragraph two, which qualifies the right? Human rights take meaning only when applied to individual circumstance so more information will be needed here.

2. Possible breaches of equality legislation

Winchester Prison, number 4: It is clear from the statements that the DDA was not applied and a case could be brought against the public authority.

Winchester Prison, number 3: failure to make reasonable adjustments could lead to violation of DDA.

3. Customer service delivery

Religious items not allowed in prisons: this would not constitute human rights violation, but could be considered as part of a different framework.

Delays to deliver a health care service are not a human rights violation but it falls under minimum service delivery standards. Unjustified long delays that have direct nexus with an individual's health (deterioration/ losing life etc) may raise human rights concerns even when in prison.

Biography 5: although there is not enough evidence to bring a human rights case here, the lack of access to healthcare provision that was caused due to language barriers may raise other type of concerns. If the circumstances were different (e.g. it involved a serious illness/ operation which did not happen because of language barriers and then led to severe health implications) they could lead to an Article 2 violation if proved that the public authority was already made aware of the language difficulties.

On more than one occasions, users pointed out the lack of personalised service. While they would indicate how important this is for improving their health and personal circumstances they will then go on to justify it by saying that there are not enough staff and resources. Although this issue is not something that can be raised within the context of human rights, it is something that can be raised as part of a wider strategy for improving health service delivery standards within prison.

4. Other

Diversity/ cultural awareness of inmates: Several users indicated very low levels of diversity/ cultural awareness. This was also true for juveniles. Increasing awareness through activities/ teaching is worth exploring. London Probation has introduced a diversity/ cultural awareness programme for hate crime offenders, which is worth looking at.

Biography 2: The inmate appears to be from a Travellers community but yet he is identified as White British. The CRE (now EHRC) guidance on monitoring ethnic data and the RRA require that Traveller/ Rome/ Gypsy are identified as distinctive groups.

Annex C: Review by Human Rights Specialist of *Improving Health, Supporting Justice: A National Delivery Plan*

Dr. Theo Gavrielides
Race on the Agenda

I was asked to look at the possibility of taking a human rights based approach to the commentary within the EqIA, making human rights references explicit in the text of the EqIA and making an empowerment model the desired outcome for the users and staff involved with the healthcare provision. . Further review is highly recommended.

1. The HRA, human rights and public services

A central purpose of the Human Rights Act 1998 (HRA) is to institutionalise human rights thinking in public service provision. This would occur when it could genuinely be said that public services were provided in a way which was fair, which respected peoples' dignity and diversity and which guaranteed their rights to equal treatment and equality of opportunity. The effect would be to reduce the likelihood of human rights breaches and to improve the quality of the services provided for all users of them. What needs to be done to implement a human rights approach in public services?

The Improving Health, Supporting Justice national delivery plan (the Plan hereafter), presents government particularly DH, MoJ, Home Office and DCSF with a unique opportunity to set out actions for regional and local healthcare services to offenders that take into account what the human rights rhetoric and practice has to offer. There is strong evidence to suggest that human rights values and legislation can facilitate the delivery of the Plan's objectives by introducing them under Key Objectives 3 (mainly workforce development) and 4 (monitoring and Equality Impact Assessments).

Healthcare services to offenders (whether in custody or under community supervision) are not provided by faceless institutions, which as "public authorities" have legal responsibility under the HRA. They are in fact provided by hundreds of public sector workers facing daily challenges and dilemmas in delivering services to people who are often vulnerable and marginalised. Short of legal action where there are breaches of the Act, what are the best ways to ensure that these busy individuals do in fact treat users of services with fairness, respect, equality and dignity (i.e., in accordance with the FRED principles)?

The HRA 1998 makes it unlawful for public authorities to act "incompatibly" with the articles of the European Convention of Human Rights (ECHR) incorporated by the Act into UK law (Convention Rights). The Act therefore provides a minimum guarantee to protect people's human rights in relation to the provision of public services. The Act's purpose, however, goes further than requiring bare compliance on the part of public authorities to avoid legal action. By virtue of the legal doctrine of 'positive obligations,' public authorities may also be required to take positive action to respect and protect people's human rights. In order to achieve this objective, public authorities need to use the rights-based framework that the Act provides in the design and delivery of public services. The Act, therefore has an impact both as a law which requires protection of rights but also as a tool which should be employed to improve public service practice.

Moreover, the Convention Rights are based on the principles of fairness, respect, equality and dignity (the "FRED" principles, Butler 2005) and these principles are fundamental to the provision of high quality public services. Human rights principles therefore are intended to transform the way in which public services are delivered so that users are always treated fairly, equally and with dignity and respect. This has been described as the "human rights approach" and it has been argued that if public authorities adopted such an approach to the provision of public services, the risk of violations occurring should be reduced and overall standards should rise, leading to improved services for all (Butler, 2005).

2. Why human rights based approach?

In 2003, the Audit Commission said: *"Human rights can bring benefits to service users. Some policies, practices and legislation that result in direct benefits to service users are being influenced by the [Human Rights] Act. Mental health is going through radical reform, which is aimed at the improving quality of life for people who experience mental health difficulties. These changes have been influenced by the Act and will help to improve the standards of service and care of mental health patients. Similarly, the National Health Service Framework was written with human rights in mind. The Health and Social Care, Fire Services, and Criminal Justice Bills, to name but a few, are being improved because of the scrutiny process against human rights principles. Human Rights legislation has been used innovatively as a framework to improve the equality and dignity of people with learning disabilities in their relationships with carers and in education as part of a young citizenship programme for children"* (Audit Commission 2003).

In 2004-6, a great amount of resources was invested by government and the Ministry of Justice in particular in finding out what added value human rights principles have to customer service delivery. The Human Rights Insight Project focused on health care services and measured through qualitative and quantitative methodologies what difference human rights practices have on both consumers and public service providers. The project concluded: *"Increasing the extent to which key human rights principles are respected and*

applied in public service delivery could increase user satisfaction" (Ministry of Justice 2008).

More recently, the newly established Equality and Human Rights Commission (EHRC) carried out a thorough Human Rights Inquiry which among other things looked at the value of mainstreaming human rights in public services. Several healthcare service providers, inspectorates and regulators gave written and oral evidence. EHRC also commissioned 3 independent studies which looked at case studies of public service providers including healthcare where human rights were mainstreamed and had a positive impact on consumers and staff. The Inquiry concluded: *"In the first major study into how far public sector authorities have adopted a rights based approach to delivering services, the Inquiry found that where human rights were put at the heart of the delivery of public services, they delivered successful results"* (EHRC 2009).

3. Current state of play

In 2003, the JCHR criticised the Government's human rights policy work by saying: *'The Act has not given birth to a culture of respect for human rights or made human rights a core activity of public authorities …. Too often human rights are looked upon as something from which the State needs to defend itself, rather than to promote as its core ethical values. There is a failure to recognise the part that they could play in promoting social justice and social inclusion and in the drive to improve public services. We have found widespread evidence of a lack of respect for the rights of those who use public services, especially the rights of those who are most vulnerable and in need of protection'* (JCHR 2003).

In 2003, the Audit Commission survey of 175 public authorities concluded that: 'The HRA can help to improve public services, as it seeks to ensure the delivery of quality services that meet the needs of individual service users … [However] three years on, the impact of the Act is in danger of stalling …' (Audit Commission 2003). For instance, the Audit Commission study reported that:

- 58% of public bodies surveyed still had not adopted a strategy or a corporate approach to human rights. In many local authorities, the Act had not left the desks of the lawyers. Most local authorities continued to review policies and practices on a piecemeal basis and to respond to case law.
- In health, 73% of trusts were not taking action. Health bodies consistently lagged behind other public services.
- The biggest risk to public bodies was their lack of arrangements for ensuring that their contractors and partners were taking reasonable steps to comply with the Act. 61% of public bodies had failed to act.
- Of 175 public bodies surveyed, only one council had made general information on the Act available to the public. Organisations were reluctant to promote human rights with citizens and their communities

because they feared an increase in the number of complaints raising human rights issues.

4. How can a human rights approach be introduced through the Plan?

Despite the undoubted commitment of most healthcare staff to the delivery of high quality services, all such individuals are daily faced with issues that cause consternation and distress whether on the part of service users or themselves. A human rights framework can be presented to key workers as an ethical and legal tool that they should use to deal with the conflicts and dilemmas that can arise. It is likely that the human rights framework will match people's common sense instincts about a situation. By articulating the dilemmas in human rights terms, however, it may be possible to resolve conflicts in ways that are respectful of human rights.

The implementation of a human rights approach specifically within healthcare services to offenders will be more effective if human rights are presented to workers not as a separate or novel set of standards (which might engender negative or counter-productive responses known as "reactance") but as complementary to well-established value systems such as the public service ethos and the equality and diversity agenda (which encourages intellectual absorption).

Human rights also need to be communicated, not only in terms of preventing malpractice (risk avoidance) but also as providing a useful framework to improve public service provision. Once the underlying value of human rights and its application to healthcare services have been understood, the important fact that it is grounded in statutory requirements can then be explained. The "positive duties" under equality legislation are comparable in this respect. The psychological effect on individual attitudes should then be, "this is something that can help us do our job better and it's required by law anyway" rather than "this is more red tape."

Key Objectives 3 and 4 should be expanded to include human rights. In particular:

4.1. Key objective 4 of the Plan

4.1.1. Measuring the impact on service delivery

Service delivery and the impact of new policies need to be measured to evaluate whether positive changes in attitudes and behaviour have in fact occurred, i.e., the desirable "outcomes." Impact assessment can also act as a deterrent and as a source of information, data gathering and as an evidence base. Human rights objectives will need to be developed as part of the Equality Impact Assessment tool. The objectives should complement and

reinforce what the Audit Commission and the Healthcare Commission are implementing in terms of auditing for evidence of adherence to human rights standards within the inspection process (Audit Commission, 2005; Healthcare Commission, 2005). Commentators (e.g., Butler, 2005, Gavrielides 2008) have begun to suggest how implementation of a human rights approach could be measured. We briefly consider here some of the relevant issues from the perspective of psychological science.

Generally, targets should be drawn up following a reasonably straightforward protocol: the outcome of the service in question should be defined; the principles underpinning the ECHR should then be examined in terms of their potential impact on the service (for instance, unfairness indicated by disproportionality of access or outcome, respect in terms of complaints etc). The relation between these targets and human rights consideration should be clear.

Targets relating to the involvement of service users would include the active involvement of service users in all aspects of service planning and delivery. This would include membership of relevant boards or committees, but could also include an assessment of the information provided to service users, and the practical measures employed to facilitate such involvement (such as payment of expenses etc). Qualitative assessment of progress to targets in this area would include assessments of the opinions of service users and staff in this respect.

Targets relating to training might include: the presence, extent, nature and quality of training in human rights issues. Such audits have been conducted successfully elsewhere (Northern Ireland Policing Board, 2005). Targets might also include the extent to which service users are involved in the design and provision of training and the content of such training (evaluated against the principles outlined in this report). Audits could be conducted into the recall by participants of the training materials as well as the subjective opinions of staff, service users and (of course) the learners.

If the proposal is to measure changes in behaviour, there needs to be awareness of the tendency towards the fundamental attribution error in order to avoid making it. The focus on what individuals do and how they behave may be excessively ascribed to dispositional factors (their perceived incompetence) rather than the more real but less acknowledged situational ones (lack of training, resources and consequent loss of morale among staff).

Quantitative evaluation of progress to ‘outcome’ targets might include assessment of whether there has been a decrease in number of recorded complaints about poor treatment, and a corresponding increase in number of commendations about services provided. Evaluation of quantitative targets relating to service access (equality in relation to the relative access to services by people from relevant population groups for example) is well developed in the Health Service, where well-practiced audits of diversity issues have been common for many years.

Qualitative evaluations may include satisfaction surveys. Service users could be asked the extent to which they feel that they have been treated with fairness, dignity and respect. These matters would be assessable only through subjective, impressionist or qualitative methodologies. Thus 'satisfaction' can be measured, but only through enquiring as to people's impressions. It is, of course relatively easy to measure impressions (psychologists in particular tend very readily to hand out questionnaires). Some consideration could be given to ensuring that a systematic approach is taken to such data-collection, across services and across Government. That may allow some comparison to be made over time, across services and to allow experimental comparison of initiatives in service development.

4.1.2. Six Principles for Human Rights in Public Services

Healthcare service providers to offenders should be informed that a human rights approach (adopting the FRED principles) will assist in developing and improving the quality of public services and that human rights offer a useful framework when dealing with complex and challenging issues. The emphasis should be on the expectation that the providers already act in accordance with a public service ethos and the need to respect equality and diversity and that these reflect human rights principles.

The following Six Principles of Human Rights in Public Services (or something comparable) should be adopted within public services and widely publicised.

1. the HRA is a corner-stone of our constitutional settlement
2. the values of fairness, respect, equality and dignity underpin the Act
3. these human rights principles complement existing value systems such as the public service ethos and equality of opportunity
4. human rights principles can contribute to improving public services
5. the human rights framework is useful in addressing the challenges of public service provision and
6. a human rights approach to public service delivery will constitute best practice at the same time as amounting to compliance with the law.

4.2. Key Objective 3 of the Plan

Vocational training informed by the Six Principles should be provided for all healthcare workers involved in designing and delivering public services to offenders, especially those on the front-line of provision. Such training should address the compatibility between people's belief systems and the FRED principles and should involve personal reflection on their own practices. It should use interactive techniques allowing participants to test and develop "mental models" of the application of human rights to their work. Live training is likely to be more effective than written guidance.

The 'Ten Essential Shared Capabilities' developed for mental health services may offer a useful model for embedding specified values into employee development. Further research on its efficacy would assist development of comparable standards for human rights.

Annex D: References

The original template for this work suggested listing references by diversity strand in order to facilitate updating. However, we found that a number of sources were relevant to more than one strand. For this reason, they are presented as a matrix.

Reference	Race	Religion	Age	Disability	Sexual orientation	Gender
Barclay, G., Munley, A. and Munton, T. (2005). *Race and the criminal justice system: An overview to the complete statistics 2003-2004*. London: Home Office.	✓		✓			✓
DH (2008) *Equality Impact Assessment: Guidance for policy makers*	✓	✓	✓	✓	✓	✓
Green J; Hetherton JP; Heuston J; Whiteley C; Strang J(2003) *Heterosexual activity of male prisoners in England and Wales.* International Journal of STD & AIDS; Apr 2003; 14, 4; pp. 248-252 (abstract)					✓	
Hensley C (2000) *Attitudes Toward Homosexuality in a Male and Female Prison: An Exploratory Study*. The Prison Journal; 80; 434 (Abstract)					✓	✓
Jacobson J (2008) *No One Knows: Police responses to suspects with learning disabilities and learning difficulties: a review of policy and practice*. Prison Reform Trust. Note: link is to 'No One Knows' web page from which information and reports can be accessed.				✓		
Ministry of Justice (2006) *Criminal Statistics 2006*: England and Wales	✓		✓			✓
Ministry of Justice (2006) *Statistics of Mentally Disordered Offenders*			✓	✓		✓
Ministry of Justice (2008) *Arrests for Recorded Crime (Notifiable Offences)*	✓		✓			✓

Reference	Race	Religion	Age	Disability	Sexual orientation	Gender
and the Operation of Certain Police Powers under PACE England and Wales 2006/07: Statistical bulletin						
Ministry of Justice (2008) *Offender Management Caseload Statistics 2006: Statistical Bulletin*	✓		✓			✓
Ministry of Justice (2008) *Statistics on Women and the Criminal Justice System 2005/06*. A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991	✓		✓			✓
Ministry of Justice (2008) *Statistics on Race and the Criminal Justice System – 2006/7*. A Ministry of Justice Publication under Section 95 of the Criminal Justice Act 1991	✓		✓			✓
National Statistics (2007) *Report from the review of equality data: Summary and recommendations*	✓	✓	✓	✓	✓	✓
Peplau LA (2001) *Rethinking women's sexual orientation: An interdisciplinary, relationship-focused approach*. Personal Relationships, 8, 1-19 (Abstract)					✓	✓
Prison Reform Trust (2008) *Doing Time: the experiences and needs of older people in prison.* a Prison Reform Trust briefing For older people in prison see: http://www.prisonreformtrust.org.uk/subsection.asp?id=273	✓		✓	✓		✓
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Annex E: Abbreviations

BME	Black, Minority, Ethnic
CJS	Criminal Justice System
DDA	Disability and Discrimination Act
DH	Department of Health
EIA	Equality Impact Assessment
EHRC	Equality and Human Rights Commission
HSCCJP	Health and Criminal Justice Programme
IEP	Incentives and Earned Privileges
MoJ	Ministry of Justice
NOMS	National Offender Management Service