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EDITORIALS

Healthcare services in police custody in England and Wales

Recent government U turn leaves police healthcare adrift from the NHS

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In December 2015, the UK government announced that planned changes to the commissioning of healthcare for people held in police custody in England and Wales would not proceed. These changes had been well considered (having been in planning since a key report by Lord Bradley in 2009[1]), set out formally, and described as one route to securing excellence.[2] The government announcement, however, means that the commissioning of these specialist health services will remain with police and crime commissioners instead of being transferred to the National Health Service. This sets police healthcare apart from all other healthcare services, including those that are provided in other parts of the criminal justice pathway.

The decision represents a missed opportunity. It will prevent much needed service development and could set back current healthcare delivery. It represents a policy reversal that flies in the face of several years' preparation. It seems to have been financially driven,[3] but had the proposed transfer to NHS commissioning driven service improvements as expected, the change could have improved health outcomes substantially, and ultimately saved money.

Forty one police and crime commissioners in England and Wales were elected in 2012 and now have a key role in setting local objectives and budgets. Their overall budget is in excess of £8bn, funding a workforce of over 200 000 people. This workforce is in place to deal with up to 6.6 million crime incidents[4] and over one million arrests a year, although arrests have been consistently falling since 2007.[5]

Many of these large numbers of people may not have sought healthcare in the community despite having a complex range of conditions that require investigation and treatment[6] and may be acutely life threatening.[7] The importance of providing healthcare screening after arrival in police custody is well established, although the screening methods currently used nationally require improvement[8]—something that could have been achieved through the transfer of commissioning responsibilities.

The prevalence of health disorders among people taken into police custody resembles the prevalence within the prison population—perhaps unsurprisingly given that many of them will ultimately enter prison, whether transiently to await trial or for a custodial sentence.[9] They are, however, often much more acutely ill than all but the newest prisoners.

In prisons, the combination of high morbidity[10] and commitment to equivalence of healthcare[11] has led to relevant healthcare services being commissioned from the NHS since 2006. Although this handover of commissioning responsibility took a decade after the publication of the landmark report *Patient or Prisoner*[12] in 1996, recognition that these changes identified substantial unmet needs[13] should weigh against abandoning, or even delaying, similar reforms for those in police custody. Furthermore, failure to see through the commissioning changes goes against current international trends in progressive thinking about healthcare systems, which highlight the need for service integration across complex clinical pathways.[14]

Lord Bradley's proposal for the development of liaison and diversion services—integrated across the whole criminal justice pathway and with other relevant services in order to provide information where required and transfer people away from custodial care at earlier points in the criminal justice pathway—is still government policy. There is increasing recognition that these services can be effective,[15] and mounting evidence that healthcare interventions that broadly sit within the liaison and diversion portfolio, such as court based mental health interventions and intensive drug treatments can ultimately save money.[16]

The government's U turn on commissioning health services in police custody seems set to leave these services disconnected from the NHS as a whole, and from one another, through disjointed commissioning. This is a far cry from the seamless integration that had been sought, and that is still government policy.[14] The decision seems more focused on a short term

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financial fix than longer term strategic health and economic gain.

We believe that consistent NHS based health commissioning arrangements across the entire criminal justice pathway would result in considerable improvement in the safety of the community and those arrested as well as cost benefits for the government. We therefore hope that this position can be restored at the earliest possible opportunity.

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