

Health needs assessment of offenders in the community

*Cheshire East, Cheshire West & Chester, Warrington and
Wirral*

June 2013

Michael Lloyd, Independent Researcher
Commissioned by NHS Cheshire, Warrington and Wirral



Cheshire, Warrington and Wirral



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Disclaimer

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The hyperlinks / website references in this report were correct at the time of publishing.

TABLE OF CONTENTS

	Page
SUMMARY	4
Context & Approach	4
Key Recommendations	6
FULL REPORT	11
CHAPTER 1: CONTEXT	11
1.1 Background	11
1.2 Policy Context	12
CHAPTER 2: APPROACH	16
2.1 Overview of HNA process	16
2.2 Aim and objectives	17
2.3 Project steps	19
CHAPTER 3: SUMMARY FINDINGS	21
<i>Findings – by key theme:</i>	
3.1 Alcohol and drug misuse	21
3.2 Mental health and learning disabilities	40
3.3 Access to healthcare and role of GPs	49
3.4 Joined-up services need joined-up systems	52
<i>Spotlight on:</i>	
3.5 Female offenders	54
3.6 Approved Premises	58
3.7 Military veterans	61
3.8 Prison healthcare	63
3.9 Custody suites	66
CHAPTER 4: RECOMMENDATIONS	72
References	79
Glossary	82
APPENDICES – <i>**Separate Document**</i>	

CONTEXT & APPROACH

- The commissioning of this health needs assessment (HNA) of offenders in the community couldn't be more timely given the raft of changes impacting on health, well being and social services in 2013. This includes the wide scale impact of reform associated with Health and Social Care Act 2012 upon the commissioning of health services for people in contact with the Criminal Justice System (CJS) in England.
- It is well documented that many prisoners have poor health which consequently affects the health and wellbeing of the wider public as prisoners move into and out of the general community, experiencing complex and intersecting needs - including poor physical and mental health, substance misuse, heightened self-harm and suicide risk, homelessness and reduced life expectancy.
- There is a wealth of research and information on the health of prisoners, but very little relating to the health of offenders in the community. Outside of custody, offenders often face a double disadvantage of both health inequality and difficulty of access to health services. The relatively poor health of prisoners does not suddenly abate on release (often it gets worse) whilst offenders who do not go through the prison system are often hard to reach or engage with – often living at the margins of local communities and under-represented in local needs assessments or strategic commissioning plans. It is this gap in understanding and evidence that this study seeks to fill.
- A 'rapid appraisal' approach was applied, to deliver this HNA in the four month timescale. A participative method was adopted to yield a rapid overview of the population and health needs – focusing primarily on perceptions of need and qualitative feedback. Key activities in this process were:
 - Semi-structured interviews with 32 staff, key stakeholders and personnel who work with offenders across Cheshire, Warrington and Wirral;
 - 33 one-to-one interviews with offenders in the community, to make comparison and triangulate the issues identified by stakeholders, drawing out needs rather than 'demands';
 - A secondary data collection exercise, requesting statistics from agencies relating to the population being studied, or requests for signposting to supporting epidemiological statistics;
 - Production of a report of observations, key thematic findings and recommendation associated with developing the evidence base, understanding and effective services for offenders.
- Through meshing together existing evidence on offender health needs with findings from fieldwork, the objectives of the work are to:
 - Summarise existing local evidence on offender health needs;
 - Integrate findings from fieldwork undertaken with offenders in the community and stakeholders, to present an holistic overview of perceived need;
 - Describe key characteristics of need for the offender population relevant to commissioning health services;

- Recommend actions for improvement, bearing in mind the new commissioning landscape post-April 2013 – including the pivotal role of Clinical Commissioning Groups (CCGs) and other co-commissioners.
- Interviews with offenders were conducted at a variety of locations across Cheshire, Warrington and Wirral. An interview venue from each of the four Local Authority areas covered by the study was chosen, and facilitators asked to ensure that any offenders willing to be interviewed should be from Cheshire, Warrington or Wirral. A summary matrix, that is included in the Appendices data compendium, follows. One-to-one interviews were conducted with all offender participants, lasting between 10 and 40 minutes. Appendix A1 and A2 present summary tables and questionnaire proformas used in the interviews.

OFFENDER INTERVIEWS										
33 interviews										
Location of interview	Interviews	Offender residency								
Linden Bank AP	10	1	2	3	4	5	6	7	8	10
Bunbury House AP	5	11	12	13	14	15				
Tomorrows Women Wirral	6	16	17	18	19	20	21			
Crime Reduction Initiatives	10	22	23	24	25	26	27	28	29	31
Other - Peer mentors	2	32	33							
	33									
KEY:										
Cheshire East in yellow										
Cheshire West in orange										
Warrington in blue										
Wirral in purple										
Halton in grey										

- Interviews with the strategic stakeholders and offender cohorts identified four key themes or topics that were common 'threads' in a majority of conversations, relating to the characteristics or health needs of offenders in the community and drivers of reoffending. These were:
 - Underlying **alcohol and drug misuse** issues.
 - **Mental health and learning disabilities**.
 - **Access to healthcare** and the role of General Practitioners (GPs) in particular.
 - Joined-up pathways, to reduce reoffending and improve health outcomes, require **joined up systems** and evidence sharing.
- Chapter 3 presents summary findings relating to these four topics at the outset, before spotlighting several other themes that help to differentiate the various needs relating to healthcare and reoffending drivers of offenders when in the community (including sections on female offenders and military veterans). There are 'key fact' text boxes at the start of each section of the Key Findings chapter.

KEY RECOMMENDATIONS

- The remaining pages in this section present key recommendations, together with supporting narrative based around key findings. The opening nine recommendations (labeled R1 to R9) are ordered thematically according to the nine topics presented in Chapter 3.
- Given the scarcity of information included in existing local Joint Strategic Needs Assessments (JSNAs) relating to offender health needs, recommendations inevitably focus upon strengthening the evidence base for commissioners. Further detail concerning each recommendation is included in Chapter 4.

<p>R1: Critically assess the impact of alcohol misuse services</p>	<p>Within local JSNA evidence reviews, specific recommendations for commissioners relate to offender health and alcohol misuse – for example, the Cheshire West and Chester JSNA recommends that <i>“the high level of need in relation to alcohol amongst offenders requires a review of the level and impact of services for this specific client group”</i>.</p> <p>Local evidence in the JSNAs should be enhanced and actively publicised to commissioners, to support evaluation of ‘what works’ and identify patterns unique to their locality, such as the binge drinking needs associated with Warrington offenders identified in the 2012 Cheshire Probation Trust (CPT) strategic needs data in Chapter 3.1. Impact assessments should be commissioned where there are gaps in local evidence of service effectiveness.</p>
<p>R2: Map the gaps in effective drug recovery service provision</p>	<p>As with the needs of offenders with alcohol misuse problems, it is important to join up actions across the locality with regard to drug recovery. Within local JSNAs specific local recommendations for commissioners relate to mapping gaps in health provision for offenders and the development of evidence based, targeted health offender strategy. It is important to evaluate the effectiveness of current drug and alcohol interventions in supporting recovery, reducing drug misuse and impacting on re-offending across Cheshire and Merseyside, and communicate lessons learnt to commissioners in the relevant agencies.</p>
<p>R3: Share more notable practice on ‘what works’ for offenders with mental health problems/ diagnosis and learning disabilities, and keep targeting PD</p>	<p>It is vital for co-commissioners to share notable practice on ‘what works’ in the fields of mental health and learning disabilities. For example, New Directions in Warrington (an early intervention service, for individuals with low-level problems who are at risk, but would not normally be helped until their condition had deteriorated much further) has had a substantial impact on those it has worked with, including a 78 per cent (%) drop in reported crime compared to the pre-intervention rate. Understanding how and why certain services have made an impact is essential.</p> <p>In terms of learning disabilities, as a minimum improvement action, it is imperative that staff working with offenders are empowered to support and inform people with learning disabilities about the consequences of reoffending and how to improve their health.</p> <p>This study highlights Personality Disorder (PD) as a priority concern that needs greater resource. Stakeholders report that CPT recently won grant funding with partners in Cheshire East and Cheshire West to target this specific area of need, which is a positive development. Yet it is apparent that more PD service funding, commissioning and provision is needed.</p>

<p>R4: Facilitate greater access to healthcare in the community through better stakeholder communication</p>	<p>Effective engagement between offenders and healthcare in the community is reliant on a range of success factors, including knowledge and enthusiasm shown by the GP, adequate surgery staff training, and a willingness on the part of the offender to be civil. Improving communication and levels of understanding between GPs, surgery receptionists and other key stakeholders (for example, Probation staff) is necessary to ensure offenders effectively engage with support structures.</p>
<p>R5: Build on community support structures to help reduce female re-offending and improve women's health</p>	<p>Provision of the Specified Activity for Female Empowerment (SAFE) requirement for women offenders across all Cheshire Local Delivery Units (LDUs), the launch of a Cheshire Women Offenders' Strategy in summer 2012 and the continuing support by Merseyside Probation Trust (MPT) for women's centres including Tomorrows Women Wirral (TWW) illustrate a strong commitment from the local Probation services and partners towards meeting the needs of female offenders in the community.</p> <p>It is vital that those involved with sentencing understand fully the impact of the penalties and measures they can administer as alternatives to custody, and apply them proportionately. Provision for review of sentencing outcomes and the opportunity to visit women's centres such as TWW would enable magistrates to make their own assessment of effectiveness. Outcomes data from centres such as TWW should be accessible to co-commissioners.</p>
<p>R6: Gather more robust health outcome data for Approved Premises (APs)</p>	<p>'Without accommodation, nothing works' was a frequently heard retort when stakeholders were asked to explain how their service impacted upon reoffending and the behaviour of offenders. In Cheshire, the two APs provide a highly-valued regional resource, which contribute an essential, stabilising element in many offenders integration back into the community. Residents were overwhelmingly positive about the healthcare service they experience in the hostels, and managers were enthusiastic about their role in developing health promotion services, albeit with constrained resources.</p> <p>One of the gaps in this study, however, is the inclusion of outcome statistics that show 'before and after' evidence of how a resident's stay has impacted on the offender's health. In particular further evidence is needed on whether access to mental health services has improved and specifically if the gaps identified in PD provision have been filled since the fieldwork was undertaken.</p>
<p>R7: Plan ahead to cater for the needs of military veteran offenders</p>	<p>The recent research findings from King's Centre for Military Health Research into offending by military veterans (quoted in Chapter 3.7 of this report) created a wealth of media headlines recently. With large numbers of military personnel due to be made redundant in summer 2013, and a large proportion returning to the North West, the health needs of veterans, a small percentage of whom are offenders, is an emerging issue that will have implications on both health and CJS organisations.</p> <p>How the needs of this vulnerable group will be integrated within service commissioning arrangements needs to be clearly articulated. For example, whilst not the responsibility of CCGs when in custody, on release back into the community the veterans will create an often unique demand for services that CCGs have a duty to cater for.</p>
<p>R8: Regularly assess health needs in the Cheshire prisons</p>	<p>Healthcare provision and offender health needs in the three Cheshire prisons is assessed through detailed health needs assessments. The last HNAs for HMP Risley and HMPYOI Thorn Cross were published in January 2011 and the refresh of these is awaited. It is essential that the impetus to update the three Cheshire prison HNAs is maintained, as they are an essential component of the evidence base on local offenders.</p>

<p>R9: Develop an appropriate evaluation framework to measure the full impact of custody suite healthcare provision on offender health outcomes and recidivism.</p>	<p>As with 'early adopters' in any walk of life, those trialing new ways of working or technologies provide vital learning points that inform enhancements to future rollouts of programmes or technologies. The same is true of the Early Adopter model of healthcare in custody suites. The commissioning of the new Tascor healthcare contract in Cheshire Custody Suites from May 2013 seeks to stretch further the benefits of proactive health promotion and healthcare.</p> <p>Being able to measure impact and outcomes, rather than process such as number of referrals, requires an appropriate evaluation framework to be devised, and this in turn requires effective monitoring and information systems to be in place. It is important that any outcome measurement takes in the widest cohort possible – ideally extending health screening, for example, to all detainees and not just those seen by the healthcare provider for medical treatment.</p> <p>Those who are voluntary attendees could easily be an 'invisible' cohort when evaluating healthcare in custody, so it is important to create innovative monitoring processes in 2013.</p>
<p>R10: Roll out more joined up approaches to cater for complex needs</p>	<p>Within the CJS and health arenas, it is not uncommon for individual agencies to generally focus on improving outcomes for the neediest within their service (for example the most mentally ill or the most prolific drug users) but often miss those who have multiple needs. Thus, people may not meet the threshold of any given agency to trigger the most comprehensive intervention, despite the scale of their problems or the harms caused to the communities in which they live. Participants from a range of agencies cited the problems they experience effectively managing offenders and their healthcare needs when, in particular, offenders present with a mix of PD and other interconnected drug misuse characteristics.</p> <p>The Drug Interventions Programme (DIP) shows how multi agency working is key to tackling health and crime reduction outcomes. The same model should apply for wider health needs. Commissioners need to build on notable practice, such as Integrated Offender Management (IOM) that has delivered on reoffending outcomes so effectively in Warrington and parts of Merseyside. Post April-2013, new structures for sharing best practice, between agencies and across geographic boundaries, need to be clearly defined for all Cheshire strategic partners, so as to underpin the most comprehensive service provision for those with complex needs.</p>
<p>R11: Seek new opportunities for joined up commissioning.</p>	<p>If commissioning strategies are not integrated, there is a potential gap in provision for the commissioning of services for people experiencing dual diagnosis and complex needs. Identifying common priorities and synergies within the various health, CJS and community safety strategies (including the Police and Crime Commissioners (PCC) commissioning strategies for Cheshire and Merseyside) is an obvious first step. It is important to commission recovery orientated care pathways in tandem and across boundaries, to ensure efficient use of resources but most importantly maximise the benefits of continuity of care for the service user.</p>
<p>R12: Improve continuity of care for those discharged from prison</p>	<p>Resource needs to be set aside to evaluate the pilot programme in HMP Risley regarding the assignment of a pre-release manager who engages with the offender prior to release and physically supports them to register with a GP and other healthcare processes, together with the HMPYOI Styal application of an outcome based payment model for through-the-gate continuity of care and handover.</p> <p>Commissioners should also consider the merits of rolling out the HMP Liverpool community prison 'Offender Passport' across the Cheshire</p>

	<p>prisons, aimed primarily at addressing the health needs of offenders serving sentences of less than 12 months who do not have support from Probation when they are released. This involves the Community Prison Officers collecting information on a range of health needs (from health issues relating to alcohol and drug misuse, to wider health needs including accommodation, employment/training needs, relationship status and financial situation) and working together to address these needs. On release, the offender is then offered a referral to a mentoring project.</p>
<p><i>R13: Accurately reflect offender needs in JSNA refreshes</i></p>	<p>In September 2012 the Government completed a public consultation on draft guidance on JSNAs and Joint Health & Wellbeing Strategies (JHWS). Critics argue that there is a lack of reference in the draft guidance to the deep inequalities often experienced by the most excluded and marginalised. The four respective JSNAs in Cheshire East, Cheshire West, Warrington and Wirral need to have access to consistent, comprehensive and regular evidence on offender health needs. A review of the present JSNAs (presented in Appendix A4) reveals an inconsistent and patchy local evidence base.</p> <p>However, notable practice exists within Cheshire – for example the CPT partnership reports, including updates on offenders’ dynamic risk factors, are described in Appendix A5.</p> <p>In addition, Cheshire and Merseyside commissioners are fortunate to have specialist academic expertise so close to hand, notably in the form of Liverpool Public Health Observatory (University of Liverpool), which should be drawn upon to make sure evidence is refreshed on an annual basis. This type of research could benefit considerably from a quantitative survey being conducted with offenders in the community, to add to primarily qualitative findings presented in this study, and annual refreshments to the prison and custody suite HNA documents.</p>
<p><i>R14: Promote evidence and share understanding</i></p>	<p>Active awareness raising with commissioners and decision makers in the range of governance bodies who will influence offender healthcare provision (CCGs, Health and Wellbeing Boards HWBs, PCCs) is required in 2013, to establish:</p> <ul style="list-style-type: none"> • Whether local commissioning plans explicitly recognise the service needs of offenders and ex-offenders, including health and re-offending prevention services? • Will offenders be consistently supported to maintain continuity of health and social care from prison to community, across the patch? • Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the HWB? • Whether the costs of not addressing offender health needs are fully understood, or if cost effectiveness reviews are planned?
<p><i>R15: Strengthen the existing evidence base</i></p>	<p>Because the scope of this HNA is broad (covering large parts of Cheshire together with Wirral in Merseyside), and time limited, the number of people interviewed per authority area was relatively low and hence the number of sub-regional recommendations specific to each JSNA is limited.</p> <p>Further work is needed to gel together the findings from the various needs assessments that are ongoing locally, whilst gaps could be filled in the coverage of this reporting through:</p>

	<ul style="list-style-type: none"> • Gathering more up-to-date statistics from treatment service providers and other agencies, on prevalence rate changes specific to the offender population. • Interviewing prisoners who are about to return to the community, prisoners recently released, and custody suite visitors - to better identify issues relating to transition between detention and community.
<p>R16: Monitor wider health needs associated with welfare reform</p>	<p>The wholesale changes being implemented in 2013 to the welfare system, including the introduction of Universal Credit and housing benefit reforms, will transform the way benefits and other income support are administered, and radically alter the social housing sector. There are a number of areas that decision makers need to monitor closely with regard to the wider determinants of health:</p> <ul style="list-style-type: none"> • Stakeholders pinpoint the lump sum payment of housing benefit to the tenant rather than landlord as a potential trigger for bingeing and potential drug/alcohol overdose (in the case of substance misusers) at times of the month when benefits are paid. Given the links identified between substance misuse and offenders reoffending, this should be monitored closely. • The potential for a reduction in social housing options available to vulnerable groups is a concern, reflecting the likelihood of Registered Providers (RPs) struggling to maintain stock levels particularly in areas where rent defaults are common. The spinoff effects of this was identified in interviews with residents in the two APs visited. For many, low quality private rented accommodation is the only option on leaving APs. The common lack of decency standards in the private rented sector, coupled with the likelihood that offenders may seek out landlords who don't request rigorous reference checks and who are frequently owners of poorer quality accommodation, presents a longer term health risk. • Budget management issues, associated with the Universal Credit lump sum payments, cause massive direct financial pressures both on service providers and recipients of benefits. Some stakeholders query whether there will also be indirect impacts and cutbacks, for example to the quality of food bought for families, money spent on prescriptions, and heating bills. There are a whole range of predicted spinoffs and interlinked themes – including landlords not getting rent directly, creating new problems of evictions, homelessness and possibly relationship breakdown. The indirect measures of 'stress' on determinants of health require innovative monitoring and tracking of impact to be put in place.

- The recommendations in this report should contribute towards greater collaboration and increased harmonisation in outcomes monitoring, and support joint working towards shared goals. A series of presentations are being planned across Cheshire, Warrington and Wirral to help define the links between this HNA report and complimentary outcome frameworks and indicators, including the Public Health Outcomes Framework (PHOF).

CHAPTER 1: CONTEXT

1.1 Background

1.1.1 The commissioning of this health needs assessment (HNA) of offenders in the community couldn't be more timely given the raft of changes impacting on health, well being and social services in 2013, and the major impact of reforms associated with Health and Social Care Act 2012¹ upon the commissioning of health services for people in contact with the Criminal Justice System (CJS) in England.

1.1.2 It is well documented that many prisoners have poor health which consequently affects the health and wellbeing of the wider public as prisoners move into and out of the general community², experiencing complex and intersecting needs - including poor physical and mental health, substance misuse, heightened self-harm and suicide risk, homelessness and reduced life expectancy. Statistics from the latest Ministry of Justice Compendium of Reoffending Statistics and Analysis³, quoted in a November 2012 National Health Service (NHS) Confederation briefing paper⁴, highlight that:

*Outside of custody, offenders often face a **double disadvantage of both health inequality and difficulty of access to health services.** The relatively poor health of prisoners does not suddenly abate on release.*

- In the week following their release:
 - female prisoners are 69 times more likely to die than females in the general population.
 - male prisoners are 29 times more likely to die than males in the general population.
- It is estimated that up to 30% of offenders have a learning difficulty/disability.
- 24% of prisoners with a drug problem are injecting drug users. Of these, 20% have hepatitis B, and 30% have hepatitis C.
- Among female prisoners, 40% have a long-standing physical disability, and 90% have a mental health or substance misuse problem.
- Less than 1% of ex-offenders living in the community are referred for mental health treatment.
- In prisons, the smoking rate is as high as 80% – almost four times higher than the general population.
- 63% of male prisoners and 39% of female prisoners are hazardous drinkers.

1.1.3 There is a wealth of research and information on the health of prisoners, but very little relating to the health of offenders in the community. Outside of custody, offenders often face a double disadvantage of both health inequality and difficulty of access to health services. The relatively poor health of prisoners does not suddenly abate on release (often it gets worse) whilst offenders who do not go through the prison system are often hard to reach or engage with – *“they and their families may well be living at the margins of local communities*

¹ HM Government. 2012. Health and Social Care Act 2012. Access here: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html/>

² For example, see Kraemer, S., Gately, N. and Kessell, J. (2009). *HoPE (Health of Prisoner Evaluation): Pilot Study of Prisoner Physical Health and Psychological Wellbeing*. Edith Cowan University

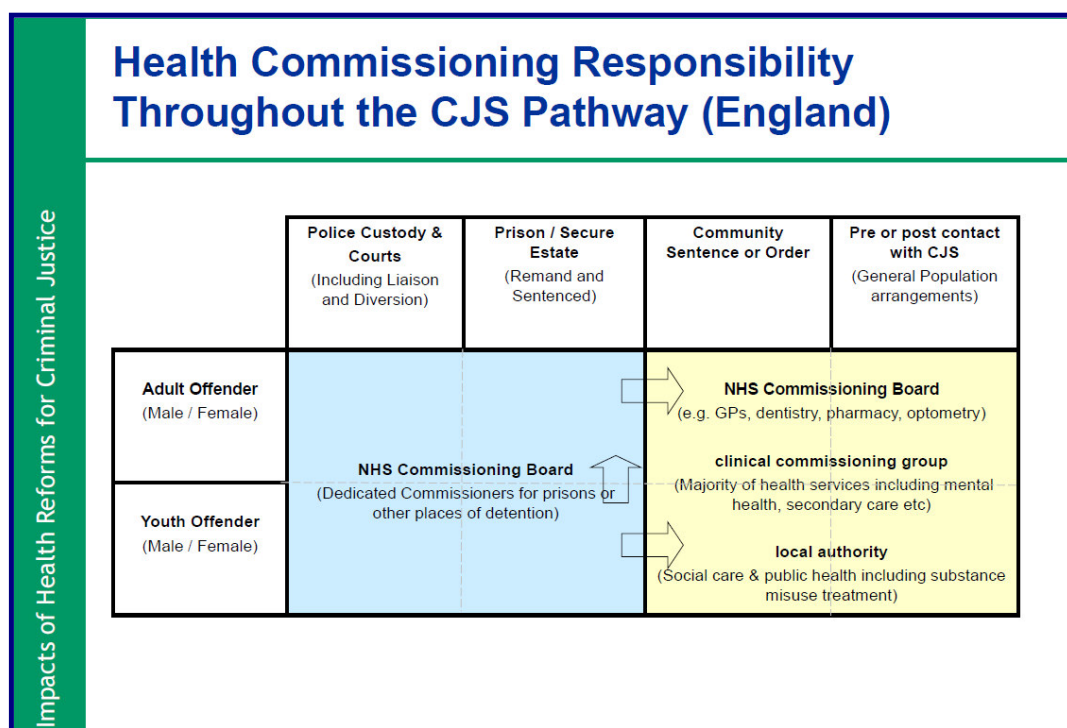
³ Access here: <http://www.justice.gov.uk/statistics/reoffending/compendium-of-reoffending-statistics-and-analysis>

⁴ Access here: <http://www.nhsconfed.org/Publications/Documents/criminal-justice-system-agencies.pdf>

and thus fail to show up or be under-represented in local needs assessments or strategic commissioning plans⁵. It is this gap in understanding and evidence that this study seeks to fill.

1.2 Policy context

- 1.2.1 Policy drivers backed by considerable investment improved healthcare in prison during the last decade. *“In addition the disciplining of life and reduced access to alcohol and drugs prison might afford a protective factor for many offenders. However in the community many offenders seem to have difficulty accessing mainstream health services. These offenders tend to over-use crisis services such as Accident and Emergency centres, but enjoy little in the way of preventative healthcare or health promotion⁶.”*
- 1.2.2 So how does all of this look through a service commissioning lens? Existing health care arrangements for people in contact with the CJS changed substantially from April 2013, as did the options available to those commissioning health and wellbeing services for offenders. The impact of health reforms on commissioning responsibility for people travelling along the ‘criminal justice pathway’ is neatly summarised by Marshall (2012) in the graphic that follows.



Graphic source: Marshall, S (2012) Presentation slides: ‘The Impacts of Health Reforms for Commissioning of Services for People in Contact with the Criminal Justice System (in England)’⁷

⁵ Clinks Briefing on the new health commissioning landscape (August 2012). Access here: <http://www.clinks.org/sites/default/files/Members%20Briefing%20-%20Offender%20Health%20August%202012.pdf>

⁶ Brooker, C et al (2008). Access here: <http://www.nacro.org.uk/data/files/nacro-2008071500-176.pdf>

⁷ Access here: <https://www.gov.uk/government/publications/2012-national-iom-conference>

- 1.2.3 As stated in a recent ‘frequently asked questions’ guide to new roles and responsibilities: *“Clinical commissioning groups (CCGs) will be responsible for commissioning emergency care, including A&E and ambulance services as well as out-of-hours primary medical services, for prisoners and detainees present in their geographical area. CCGs will also be responsible for commissioning health services for adults and young offenders serving community sentences or released under supervision on license by probation”*.⁸
- 1.2.4 Meanwhile, prison health services (including drug and alcohol treatment) are now the responsibility of NHS England, formerly established as the NHS Commissioning Board but renamed on 26th March 2013. One NHS England area team in each of ten regional areas is designated to take the lead commissioning role for prison health care in that region. In the North West of England this rests with NHS Lancashire.
- 1.2.5 For effective and efficient commissioning of services for offenders post-April 2013, it is vital that all partners involved in offender management and care delivery across Cheshire/Warrington/Wirral have a shared understanding of the roles of NHS England, CCGs, Local Authorities and HWBs.
- 1.2.6 This variation in commissioning process, between services for offenders in the community and services for those in detention, is important to clarify at the start of this report, as the boundaries of care and responsibilities for offenders’ health are often blurred. This study differentiates between the two quite distinct areas of commissioning (community setting versus healthcare in police custody/prisons/secure estate - the areas shaded blue and yellow in the preceding graphic), focussing the majority of fieldwork on offenders and stakeholders in community settings, to understand how services cater for their needs whilst in the community.
- 1.2.7 However, it is essential to understand the healthcare links back to detention, as all adult offenders will have spent at least some time in one or more of the detention facilities (in custody suites, court or prison) and that care will to some degree impact on the offender, families and wider community. As the Department of Health (DH) publication ‘*Public health services for people in prison or other places of detention, including those held in the Young People’s Secure Estate*’ (November 2012)⁹ explains, *“most of those who enter prison or other accommodation of prescribed description spend most of their lives in the community, so any public health interventions and investments whilst in custody will have positive ‘ripple’ effects on their families and wider social contacts”*. The fieldwork therefore included a limited number of interviews with staff and other strategic stakeholders in Cheshire custody suites and Cheshire prisons (HMPYOI Stryal, HMP Risley and HMPYOI Thorn Cross).
- 1.2.8 Crossovers and possible joint-priorities for community and ‘secure estate’ service issues are identified, to help commissioners pinpoint where joined-up delivery could be most effective. It is important to stress that in addition to this report on the needs of offenders in the community, other research studies and HNA exercises have been commissioned locally to assess in more detail the needs of offenders in detention and also the specific issues affecting vulnerable groups like military veterans.
- 1.2.9 Before presenting in more detail the approach adopted in gathering intelligence on the needs of offenders in the community, it is worth initially presenting some of the key policy challenges and changes affecting the distinct areas referred to in this section – offender healthcare and management in the community; and offender care in the ‘secure estate’.

*For effective and efficient commissioning of services for offenders post-April 2013, it is vital that all partners involved in offender management and care delivery have a **shared understanding of the roles of NHS England, CCGs, Local Authorities and HWBs***

⁸ Access here: <http://www.commissioningboard.nhs.uk/files/2013/03/offender-comm-faqs.pdf>

⁹ Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127242/29-People-in-prison-specification-121025.pdf.pdf

Healthcare of offenders in the community

1.2.10 This study only considers adult offenders – who can be sentenced at a magistrates’ court or the Crown Court, and the sentencing options are immediate custody, a suspended sentence order, a community order, a fine, a conditional discharge or an absolute discharge. There are three types of offenders on sentences¹⁰ which are managed in the community:

- those who are serving community sentences;
- those who are on suspended sentences; and
- those who are on licence (the second part of a 'determinate' sentence, where part of it is served in prison and part on supervision in the community).

1.2.11 Wholesale changes are presently being put forward by Government regarding how offenders in the community should be managed. The *‘Transforming Rehabilitation: A revolution in the way we manage offenders’* consultation document followed on from *‘Punishment and Reform: Effective Probation Services’*, published in March 2012, which also invited stakeholders to respond to proposed changes to the delivery of Probation Services in England and Wales. The former publication contains the Government response to the consultation submissions received as well as a number of new proposals and discussion questions for consideration by stakeholders.

1.2.12 As the CLINKS summary from January 2013 neatly explains, the latest Government publication “*proposes to extend the principle of competition into the Probation Service, contracting out the supervision of the majority of low to medium risk offenders to private and Voluntary & Community Sector (VCS) providers, and paying providers according to their success in reducing reconviction rates. Services would be commissioned nationally across 16 geographical contract areas, and there would be a reduction in the current number of Probation Trusts. It is hoped that a greater diversity of providers, and the money saved by new financial models, will allow an extension of rehabilitative interventions to offenders released after serving sentences of less than 12 months.*”¹¹

1.2.13 The ‘rehabilitation revolution’ and proposed changes to Probation Services, is one part of the policy backdrop against which this assessment of community health provision for offenders is set. In April 2013 far-reaching changes impacted upon the planning, commissioning and delivery of drug and alcohol services, including the National Treatment Agency for Substance Misuse (NTA) being abolished and its key functions transferred into Public Health England. Therefore, together with Probation staff, treatment agency staff and managers across Cheshire were engaged in this study to understand the pressures and service issues associated with supporting offenders in community settings.

1.2.14 In addition, GPs and the offenders themselves contributed essential feedback on service needs, whilst visits to TWW enabled appraisal of the often distinct needs of female service users. Interviews with staff and residents in the two APs in Cheshire (Linden Bank and Bunbury House) provided an important perspective on accommodation and supervisory needs of offenders.

In April 2013 far-reaching changes will impact on almost every aspect of offender healthcare - including the National Treatment Agency for Substance Misuse being abolished and its key functions transferred into Public Health England

¹⁰ Access here: <http://open.justice.gov.uk/how-it-works/>

¹¹ Access here: <http://www.clinks.org/sites/default/files/Members%20Briefing%20-%20Transforming%20Justice%20January%202013.pdf>

Healthcare in detention / secure estate

- 1.2.15 As well as offenders, peer mentors, treatment agency staff, sentence managers and key workers in the community, the fieldwork included interviews with strategic stakeholders in Cheshire custody suites (managers, healthcare staff) and the three Cheshire prisons (managers, staff on the wings, healthcare providers) to incorporate a broad overview of services for people who are detained prior to release into the community.
- 1.2.16 The limited scope of this study means that this element of the reporting is restricted to presenting findings from stakeholder meetings, and signposting to key findings from more in-depth studies/HNAs that exist already - including the three prison HNAs and the Cheshire custody suite HNA completed in 2012 which was produced for the latest healthcare commissioning exercise. No interviews were conducted with offenders in custody or offenders in HMPYOI Styal, HMP Risley or HMPYOI Thorn Cross.
- 1.2.17 Just as governance and delivery structures for healthcare in the community are in a period of transition, the same is true of healthcare in secure accommodation. For example, the following table summarises some of the key changes in service commissioning.

Accommodation	Current / Transitional Commissioner	Commissioning Responsibility from 2013/14	Approximate Resources 2012/2013
Prisons & Young Offender Institutions	NHS/NOMS	NHS	£470m
Secure Children's Homes	NHS	NHS	£1.4m
Secure Training Centres	Youth Justice Board	NHS	TBC
Immigration Removal Centres	UK Borders Agency	Mid-transition to NHS	£6m
Police Custody Suites	Individual police forces	Mid-transition to NHS	£66m
Courts (Liaison and Diversion Services)	DH Funded	NHS	£19.4m

Table source: Taken from NHS Commissioning Board (February 2013) 'Securing Excellence in Commissioning for Offender Health', (page 7). Access here: <http://www.commissioningboard.nhs.uk/files/2013/03/offender-commissioning.pdf>

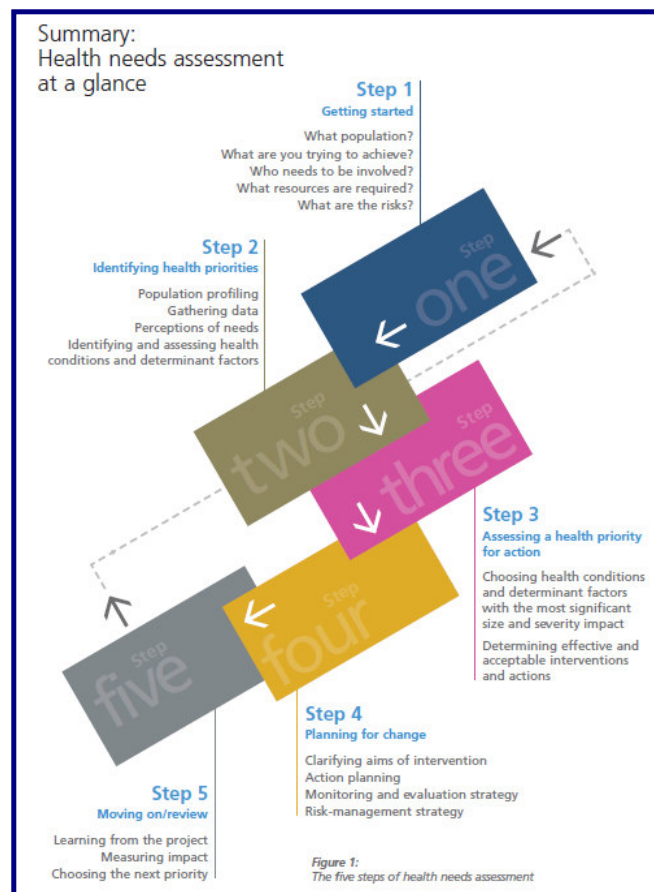
CHAPTER 2: APPROACH

2.1. Overview of HNA process

“Health problems only generate a need for health services to the extent that those services are effective at dealing with the problem. If there is no effective health service, there is no need for the service”.

Marshall,
Simpson and
Andrews (2000),
p2 [footnote 13]

- 2.1.1 Health needs assessment is a systematic process which reviews the health issues affecting a population. “The process aims to improve health, and reduce health inequalities, by identifying local priorities for change and then planning the actions needed to make these changes happen. At the core of the HNA process are four explicit criteria which focus first on the impact and changeability of issues, then the acceptability and resource feasibility of effective changes”.¹²
- 2.1.2 In considering the process for undertaking this HNA, traditional approaches were considered – including the stages commonly used for prison HNAs (for example, applying the University of Birmingham’s toolkit¹³) and the generic ‘five steps’ approach that the National Institute for Health and Care Excellence (NICE) outline in the graphic that follows.



Graphic source: Taken from NICE guide to HNA. Access here:

http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

¹² Access here: <http://www.nice.org.uk/niceMedia/documents/hna.pdf>

¹³ Access here:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034355.pdf

- 2.1.3 It was decided to adopt a rapid appraisal¹⁴ approach for delivery – a decision driven by a range of practical delivery factors, including the time constraints in delivering a HNA within four months and a lack of basic prevalence and epidemiological inputs available to the researcher in the project timescale, on health conditions affecting the offender population in the community. A participative method was adopted to yield a rapid overview of the population and health needs – focusing primarily in this study on perceptions of need. Key activities in this process were:
- Semi-structured interviews with staff, key stakeholders and personnel who work with offenders;
 - One-to-one interviews with service users who are offenders, to make comparison and triangulate the issues identified by stakeholders, drawing out needs rather than ‘demands’;
 - A limited data collection exercise, requesting statistics from agencies relating to the population being studied, or requests for signposting to supporting epidemiological statistics;
 - Production of a report of observations, key thematic findings and recommendation associated with developing understanding and effective services for offenders.
- 2.1.4 To summarise, a primarily qualitative methodology was adopted, that uses findings from offender and key stakeholder interviews to identify insight on need, and where possible triangulate this with supporting or contradictory secondary information and statistics, to identify possible priorities.
- 2.1.5 Whilst this study is focused on the needs of offenders in the community, parallel research projects have been undertaken locally on prison population needs and also thematic studies on offender sub-cohorts (for example, military veteran health). All of the research findings from these projects need to be considered together to fully appreciate the local needs of those coming into contact with the criminal justice system.

2.2 Aim and objectives

- 2.2.1 Participants in the study were sent an introductory email outlining the purpose of the research, explaining that *“NHS Cheshire has commissioned the study to inform the Joint Strategic Needs Assessments of Eastern Cheshire, Western Cheshire, Warrington, and Wirral. It is the intention that the profile of offenders will then be raised at Health and Wellbeing Boards by formalising the description of their needs in this way”*.
- 2.2.2 Mirroring the overarching aims of the 2012 ‘*Health needs assessment of adult offenders across the criminal justice system on Merseyside*’¹⁵, produced by the Liverpool Public Health Observatory, this study seeks to:
- determine the healthcare needs associated with the ‘NHS Cheshire’¹⁶ offender population in the community;
 - investigate the extent to which current service provision is addressing the healthcare needs of the offender population resident in this area.



Gathering primary data from offenders and key stakeholders, and integrating it with supporting evidence.

¹⁴ An approach outlined in more detail in this ‘toolkit’:

<http://courses.essex.ac.uk/hs/hs915/Mid%20Hampshire%20PCT%20HNA%20Toolkit.pdf>

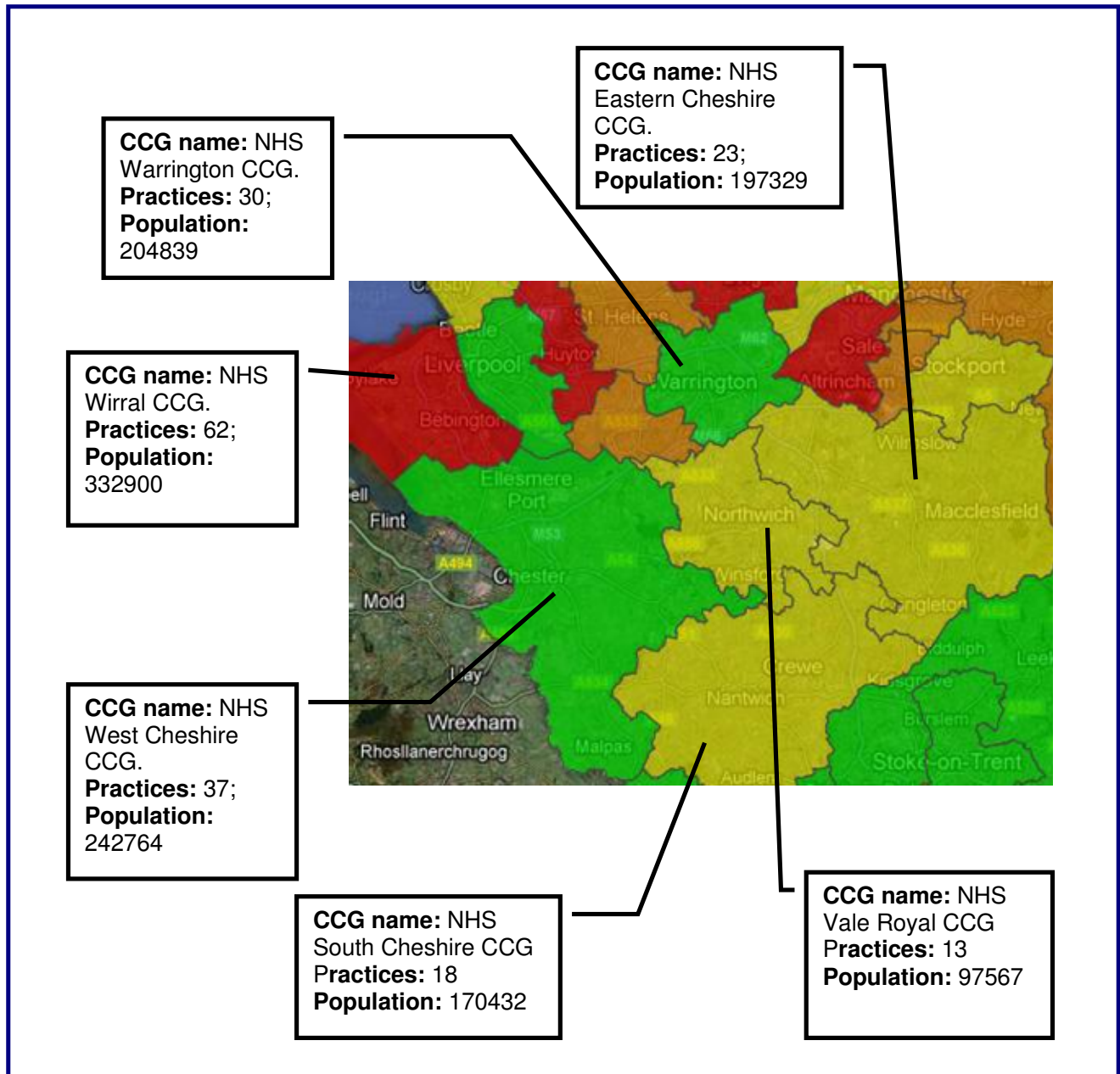
¹⁵ Lewis, C and Scott-Samuel, A (June 2012) Access here::

http://www.liv.ac.uk/PublicHealth/obs/publications/report/87_Health%20needs%20assessment%20of%20adult%20offenders_210612.pdf

¹⁶ As specified by the client, the geographical scope of the project encompasses the four local authority boundaries of Cheshire West and Chester, Cheshire East, Wirral and Warrington – referred to as ‘NHS Cheshire’ boundary in this document. NHS Cheshire encompassed the NHS Cheshire, Warrington and Wirral PCT cluster until April 2013, and incorporated NHS Central and Eastern Cheshire, NHS Warrington, NHS Western Cheshire and NHS Wirral

2.2.3 The questionnaire proformas used for both offender and strategic stakeholder interviews in this study adapted the question format and content designed by Lewis and Scott-Samuel in the aforementioned Merseyside HNA (2012). Appendix A2 presents the templates used. Through meshing together existing evidence on offender health needs with findings from fieldwork, the objectives of the work are to:

- Summarise existing evidence on offender health needs;
- Integrate findings from fieldwork undertaken with offenders in the community and stakeholders, to present an holistic overview of perceived need;
- Describe key characteristics of need for the offender population relevant to commissioning health services;
- Recommend actions for improvement, bearing in mind the new commissioning landscape post-April 2013 – including the role of CCGs (see graphic that follows, highlighting the local CCGs).



Graphic Source: Adapted from GPonline, <http://www.gponline.com/News/article/1142440/Map-CCG-authorisation-waves/>. Colour on map indicates 'wave' of CCG authorisation. Mapdata: copyright 2013 GeoBasis-DE/BKG (copyright 2009), Google.

- 2.2.4 To ensure the local CCGs (and others with commissioning responsibility) understand the wider scale and implications of offender health need, a HNA for the NHS Cheshire geographical footprint was devised that summarises the needs of as many local priority offender groups as possible, including
- Male and female adult offenders, including those serving community orders and those attending Probation under licence having previously served a prison sentence.
 - Adult offenders in both custody suites and the three Cheshire prisons (HMP Risley, HMPYOI Styal and HMPYOI Thorn Cross), using existing HNA evidence and updated perceptions of need from strategic stakeholders.

2.3. Project steps

- 2.3.1 In terms of the timetable of work, a basic four stage approach was devised to bring together as much evidence and intelligence as possible in the timescale, on the health needs of offenders across the NHS Cheshire footprint.

<i>Stage</i>	<i>Tasks include</i>
Stage One: Mapping and scoping	<ul style="list-style-type: none"> • Conducting literature reviews, summarising relevant findings from other HNAs, other local studies and policy documents; • Assessment of available relevant data sources; • Compiling a detailed description of the offender population and flows through the CJS; • Mapping of service provision across the offender pathway; • Preparation of fieldwork 'proformas' and interview resources
Stage Two: Fieldwork	<ul style="list-style-type: none"> • Acquiring intelligence from stakeholders (including offenders) to identify priority health issues, barriers to accessing services and barriers to delivering services.
Stage Three: Analysis	<ul style="list-style-type: none"> • Collation and analysis of available supporting data and statistics; • Analysis of data obtained from stakeholders, linking findings from existing studies/HNAs to the primary evidence gathered.
Stage Four: Presentation of findings	<ul style="list-style-type: none"> • Drawing conclusions from data, summarising key findings and drafting recommendations; • Report writing – with 'Consultation Draft' circulated April 2013 for comment, and amended Final Report released June 2013.

- 2.3.2 Appendix A3 outlines in more detail the methodological issues surrounding this study.

- 2.3.3 A purposive sample of who to engage with was selected and assessed following review with the client project lead in the first two weeks after project inception. The two strands of fieldwork revolved around:

- '**Offenders**' (referred to interchangeably as services users, residents or clients, dependant on the community setting). The list of offenders to interview was generated through partnership working with local Probation managers and other organisations that have close contact

with offenders in the community. All engagement with offenders was in one-to-one interviews, given the sensitive nature of the subject matter and to facilitate engagement (see Appendix A3 for more on issues to consider when interviewing offenders).

- **‘Stakeholders’** Qualitative engagement with stakeholders other than offenders was with two key groups, primarily through one-to-one interviews and group work:
 - strategic leads involved in workstrands that are directly involved with offender health commissioning in Cheshire / Warrington / Wirral (such as CCG members; senior Police and Probation representatives).
 - staff and ‘on-the-ground’ practitioners representing offender service providers - including offender managers from Probation, treatment agency staff and GPs, and the female support group TWW.

2.3.4 A full list of offender and stakeholder activities, including location and roles, is included in Appendix A1.

2.3.5 The remainder of this report covers:

- Key findings [grouped thematically according to topics that emerged].
- Recommendations.

2.3.6 The supporting statistics on services and populations are in the Appendices, grouped by the four authority areas where possible (for Cheshire East, Cheshire West, Warrington and Wirral) to support JSNA development.

2.3.7 It is hoped that this study will fill several gaps in understanding, linking perceptions of need and observation of service effectiveness – and help identify often unique healthcare issues relating to specific offender cohorts and dynamic ‘re-offending’ risk factors, through for example:

- interviewing staff, peer mentors, the resident GP and service users ‘on site’ within the Pathways to Recovery treatment service in Warrington, to better gauge the key issues relating to drug misuse;
- conducting resident and management interviews in two APs in Cheshire East and Cheshire West, to identify specific issues relating to healthcare in this type of setting;
- interviewing staff and service users in TWW and a range of healthcare staff in HMPYOI Styal to draw out distinct issues relevant to female offenders.

Engagement activities undertaken across Cheshire, Warrington and Wirral, interviewing offenders and stakeholders in a variety of community settings

CHAPTER 3: SUMMARY FINDINGS

3.1 Alcohol and drug misuse

- 3.1.1 How to most effectively design services to achieve recovery from drug and alcohol dependency has been given great prominence recently in documents such as the 2010 Drug Strategy¹⁷, its 2012 review¹⁸, and the 2012 '*Medications in Recovery*'¹⁹ report.
- 3.1.2 From April 2013, Directors of Public Health (DPH) took over responsibility for delivering public health outcomes in their local area, and crucially control over the bulk of drug and alcohol funding. At the same time Public Health England (PHE) took on the role of the authoritative voice for public health from the NTA, whilst prison health services (including drug and alcohol treatment) became the responsibility of NHS England, with NHS Lancashire designated to take the lead commissioning role in the North West.
- 3.1.3 Locally, wholesale changes affecting alcohol and drug misuse service provision are bedding in during 2013. For example, in HMPYOI Styal a new three year substance misuse service began in April 2013, with the Cheshire Drug Partnership having lead on the commissioning of Lifeline and Delphi Medical²⁰ to undertake this new contract. In the Cheshire Custody Suites, from May 2013 Tascor²¹ began a new contract for delivering healthcare in the three Cheshire Constabulary suites, which is designed to be heavily reliant on enhanced health promotion expertise, effective referral and outcome-relevant signposting for alcohol and drug misusers, given the nature of a large proportion of service use. From the turn of the year CRI have provided both clinical and non-clinical drug and alcohol services in HMP Risley and HMPYOI Thorn Cross.
- 3.1.4 It is against this changing commissioning landscape that key findings from the interviews and supporting alcohol and drug misuse statistics are presented in the next section of the report. The style of offending and the management of offenders with each type of misuse are quite different, hence this section of the report is split. We start with the issue of alcohol misuse.

¹⁷ HM Government (2011) Drug Strategy review. Access here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

¹⁸ Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98095/drug-strategy2010-review-may2012.pdf

¹⁹ National Treatment Agency for Substance Misuse (2012) *Medications in recovery: reorientating drug dependence treatment*
Access here: <http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf>

²⁰ <http://www.delphimedical.co.uk/news/Delphi-Medical-achieves-prison-milestone-with-award-of-Styal-recovery-contract>

²¹ Access here: <http://www.tascor.co.uk/services/police/custody/>

CheshireOffenderHNA_REPORT_June13_Final060613

Alcohol Misuse

Key Facts:

- CPT statistics for 2012 highlight that across Cheshire as a whole:
 - 47% of offenders in the community had current alcohol misuse problems;
 - 52% had binge drinking problems;
 - 53% had a history of alcohol-related violence;
 - almost 60% had alcohol as a problem assessed as contributing to their offending behaviour;
 - and a greater proportion of women had the most serious levels of current alcohol misuse problems and binge-drinking.
- Breaking down statistics supplied by CPT and MPT to Local Authority level, in 2012 almost half (48.5%) of Warrington offenders (n = 237) had binge drinking problems. Compare that to 2011, when this figure stood at 29.4%. This was the most significant change, year-on-year, in alcohol misuse statistics for the four areas studied – CPT and MPT data is available in Appendix A5.
- The 2012 HNA for HMPYOI Styal reveals that 53% of offenders entering prison have alcohol-misuse needs - a growing problem for this female cohort.
- In stakeholder interviews, alcoholics were referred to as an 'invisible' service user, compared to other drug misusers.
- Female offenders highlighted the inconsistency between GPs with regard to their levels of understanding and attitudes to alcohol misuse, and a perceived stigma that existed when accessing primary healthcare services.

3.1.5 The Government's 2012 Alcohol Strategy²² and subsequent consultation exercise²³ have firmly placed the interconnected issues of alcohol over-consumption, alcohol-influenced behaviour and impacts to the fore in 2013.

3.1.6 In terms of alcohol recovery services, from April 2013, alcohol treatment data outcomes are included as part of core National Drug Treatment Monitoring Systems (NDTMS)²⁴ dataset for drug and alcohol treatment services. Alcohol consumption is commonly agreed to be the key indicator of successful treatment outcomes. Hence from April, services are required to monitor alcohol consumption at start (assessment) and finish (discharge) of treatment via the two following measures:

- How many days in the last 28 have you had an alcoholic drink?
- On an average drinking day in the last 28, how many units of alcohol were consumed?

3.1.7 In addition, a secondary outcome measure assesses physical and psychological health as part of the core dataset as currently included in the drug Treatment Outcome Profile (TOP) form. Poor physical and mental health is strongly associated with alcohol misuse so assessment at start and finish includes:

- Client's rating of physical health status (extent of physical symptoms and bothered by illness);
- Client's rating of psychological health status (anxiety, depression and problem emotions and feelings).

²² Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98121/alcohol-strategy.pdf

²³ Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/157755/alcohol-consultation-document.pdf

²⁴ Access here: <https://www.ndtms.net/default.aspx>

- 3.1.8 The role of alcohol in crime and anti-social behaviour is widely recognised. Alcohol is a factor in an estimated 44% of violent crime. Hence, following on from a summary of key findings from the fieldwork relating to alcohol misuse, Probation statistics are presented on offender needs relating to this dynamic risk factor.

What did the interviews reveal?

- 3.1.9 The impact of alcohol misuse and the effectiveness of service provision are areas of concern for many interviewees. Key findings from interviews include

Alcohol being the ‘invisible’ addiction

The six staff involved in the HMPYOI Styal discussion group were asked what three areas were priorities for improvement – and alcohol services was included alongside better mental health provision and more resources to cope with learning difficulties. Staff were critical of the service provided to alcoholics within the prison when compared to the recovery service provided to any other substance misuser. Alcoholics were referred to as ‘invisible’, and consensus was that more was needed to be done to support this group.

The couple of female interviewees in TWW who had been detained in HMPYOI Styal were not complimentary of the general healthcare experienced there. One referred to healthcare provision relating to her alcohol addiction needs as “*horrendous*” - explaining how the prison had faxed off to confirm her prescription for propranolol but she had to wait for 6 weeks to see a doctor, leaving her without propranolol for that time. She also claimed that when she tried to get her medication, she was offered methadone instead, but refused to take that.

“If you go into A&E with alcohol related problems, you get treated very differently by the nurses... I’ve gone in sober, but shaking so much and been referred by GP to go into hospital, but still had that treatment – they make you feel like you’re a nuisance”
TWW interviewee

Understanding, attitudes and stigma in primary care

Women interviewed in TWW highlighted the inconsistency between GPs with regard to their levels of understanding and attitudes to alcohol misuse. One explained how a previous GP in the community had not been aware of alcohol referral services available on Wirral, so she had to seek out and contact Arch Initiatives herself.

Women’s specific detention needs

The 2012 Merseyside HNA published by the Liverpool Public Health Observatory found that health care staff reported that there was a perception among sentencers that sending women to prison would help them deal with their problems (e.g. drug/alcohol problems), although the reality was very different.

This was reiterated by staff in HMPYOI Styal, particularly in relation to women with complex needs involving alcohol and mental health. Prison was perceived to have a detrimental impact on the health of female offenders with multiple needs. Interviews in TWW with those who had served short stays in prison reiterated how detention can be a backward step. One had served 6 and 10 weeks in 2010 and 2012 respectively, and explained how both stays had completely disrupted her recovery regime.

Alcohol undermining accommodation options

Offenders interviewed who admitted an alcohol problem noted how finding appropriate housing was a particular concern. Where alcohol misuse triggers exclusion from hostels and other accommodation, several stakeholders noted the ease with which offenders could 'fall through the trap door' and become homeless.

The 2012 Merseyside HNA noted that *"A specialist accommodation unit provided by Merseyside Probation Trust, which links in with key housing providers, helped to mitigate this, and many treatment providers also had strong links with agencies providing housing"*. Whilst links may exist with local housing providers, several respondents highlighted the growing risk of Registered Providers and other social housing options being withdrawn from the area, as their business models are destabilised by housing welfare reforms. This would impact most on those with fewest options available – notably offenders with alcohol misuse behaviours.

What do supporting statistics and assessments tell us?

3.1.10 CPT and MPT alcohol misuse assessment data by area are included in detail in Appendix A5 – for Cheshire East, Cheshire West, Warrington and Wirral. Statistics reveal the prevalence of alcohol misuse both as a determinant characteristic and driver of offending behaviour for many offenders in the community. For example, data for Cheshire as a whole in 2012 highlight that:

- 47.1% of Cheshire offenders (1056) had current alcohol misuse problems at commencement of their supervision. 21.8% had the highest levels of needs (488).
- 51.8% of Cheshire offenders (1161) had binge drinking problems.
- 53% of Cheshire offenders had a history of alcohol-related violence (1022).
- 59.8% of Cheshire offenders (1342) had alcohol as a problem assessed as contributing to their offending behaviour.
- A greater proportion of women (5.6% higher) had the most serious levels of current alcohol misuse problems and binge-drinking. Disabled offenders had the most entrenched binge drinking issues and the highest proportions of alcohol misuse problems (61.4%).
- Alcohol-related violence was much more associated with male offenders (15% higher than females) and peaked in the 21-24 age group (63.2%).

3.1.11 A breakdown of offender alcohol misuse statistics by authority area reveals few significant increases or decreases in offenders being assessed with misuse problems, binge drinking or violence statistics. The only notable exceptions to that are:

- in Warrington, where the number of offenders assessed by CPT with binge drinking problems increased dramatically from 2011 to 2012. In 2012, almost half (48.5%) of Warrington offenders (237) had binge drinking problems. Compare that to 2011, when this stood at 29.4% of local offenders (153).
- in Wirral, between 2011/12 and 2012/13 there was a 4% fall both in the percentage of offenders assessed as having alcohol-related needs and also the number assessed as having a binge drinking problem. With

regard to the latter, 32.4% of offenders had a binge drinking problem in 2011/12 compared to 28.4% in 2012/13.

3.1.12 Local prison health needs assessments reveal the following about alcohol misuse in the three Cheshire prisons.

Findings from 2012 HNA²⁵ for HMPYOI Styal:

- *“53% of those entering HMPYOI Styal are noted as having alcohol-misuse needs. And this appears to be a growing issue. [Note: According to the 2012 Cheshire Custody Suite HNA, only 7% of the Styal prison population are from Cheshire, highlighting an obvious difficulty in joining together local healthcare for Cheshire offenders].*

<i>From analysis of OASys data:</i>		
	All female estate	HMP YOI Styal
Alcohol misuse need 2009/10	17%	33%
Alcohol misuse need 2010/11	33%	53%

Table source: Leigh, E. (2012) ‘HMP Styal 2012 - Health Needs Assessment’ (p39)

- *Alcohol is implicated in many older, first time offenders index offences.*
- *Those serving under 12 months typically have acute alcohol and drug withdrawal issues.*
- *‘Programme On Women Alcohol and Reducing Reoffending’ (POWARR) seeks to meet the individual needs of women alcohol offenders, whilst embedding recent research and emerging evidence.*
- *The most recent survey of women released from Styal found 74% reported drinking alcohol, with 32% being under the influence at the time of committing their offence.*
- *Approximately 40% of new arrivals at HMP Styal require clinical management for drug and/or alcohol dependency, with 20%+ of women at HMP Styal requiring alcohol detoxification and 331 (45%) of the opiate users also requiring alcohol detoxification. This is a significant increase on 2008 when a quarter of women admitted to Waite Wing²⁶ were alcohol dependent.*
- *Underlying issues behind women with mental health issues include alcohol, alongside drugs and general chaos, which has led to financial and violence issues.*

²⁵ Leigh, E (2012) ‘HMP Styal 2012 - Health Needs Assessment’

²⁶ Waite Wing is a quick build wing holding approximately 135 women in cellular accommodation on two spurs with mainly single accommodation. Following assessment on the First Night Centre, women with substance misuse issues are transferred to Waite Wing landing for five days or more for further assessment and observation.

- *Health care staff reported that there was a perception among sentencers that sending women to prison would help them deal with their problems (e.g. drug/alcohol problems), although the reality was very different.*
- *Dental health among women is worse than in the general population, due in part to oral neglect, often due to drug/alcohol problems or chaotic lifestyles of some offenders, combined with the effects on oral health of drug/alcohol use, smoking and poor nutrition”.*
- Recommendations in the report include:
 - *“Continue to support women to make longer term changes to their alcohol consumption;*
 - *The development of the initial alcohol pilot should be continued. This work should be cross-referenced into the wider health economy with HMP Styal”.*

Findings from January 2011 HNA for HMP Risley²⁷ include:

- *“Staff indicated that HMP Risley houses an extremely diverse range of offenders, including problematic drug and alcohol users, and that provision of holistic drug and alcohol treatment (and healthcare treatment) for such a diverse population represented complex challenges.*
- *Forty-three percent of the 134 participants who completed the HNA offender questionnaire (N=53) reported overall drug and alcohol services to be poor or very poor²⁸.*
- *Of the 134 participants who completed the HNA offender questionnaire, only six reported alcohol dependency as a diagnosed or suspected physical health problem. Daily use of alcohol was reported by several interviewees prior to detention. The majority of offenders who did not describe dependent alcohol use reported binge drinking, especially at weekends.*
- *It was also suggested that drugs and alcohol would be passed around particular groups (in HMP Risley) and that the type of substance and patterns of use would vary depending on the characteristics of a given group.*
- *Staff reported that health promotion initiatives at HMP Risley were guided and coincided with the NHS calendar and had recently included awareness sessions for alcohol use. Alcohol Awareness-Level 1 is one of the Social and Life Skills available for offenders”.*

Findings from January 2011 HNA for HMPYOI Thorn Cross²⁹ include:

- *“Whilst there are no major gaps in healthcare service provision at HMPYOI Thorn Cross, one of the most important areas for service development is in relation to providing a specific service to address offender alcohol use.*

²⁷ Russell, S and Jones, L (2011) ‘Healthcare Needs Assessment HMP Risley’

²⁸ Note: The HNA was published at the start of 2011, and since then the service has been re-commissioned to include alcohol services

²⁹ Russell, S and Jones, L (2011) Healthcare Needs Assessment HMYOI Thorn Cross

- Several interviewees attributed their mental health problems to past substance use and indicated that they were confident of not relapsing or not using substances in the same way as they had previously, particular in the case of alcohol.
- Of the 67 participants who completed the HNA offender questionnaire, not one reported alcohol dependency as a diagnosed or suspected physical health problem”.

Findings from 2012 HNA for Cheshire Custody Suites³⁰

3.1.13 Finally, as well as alcohol misuse prevalence gathered from Probation for offenders in the community and the perspectives on need in prisons, it’s important to assess the problem in relation to custody suite service use. The 2012 Custody Suite HNA notes that:

- “Based on the sample of records reviewed, 24% of detainees seen by Reliance Medical Services for medical treatment in the month of October 2011 were under the influence of alcohol on arrest, which may have contributed to their offence. However, it is not known for 47% of those seen by Reliance Medical Services if an alcohol problem existed, with only 21% admitting to having a problem. Again, the data collected largely shows that it is not known if detainees are in contact with services for their alcohol issues.
- Middlewich and Runcorn Custody Suites had the higher number of detainees who were under the influence of alcohol on arrest.
- The following table shows the OASys³¹ scores of those open cases in the quarter 2 period;

	Score 0	Score 1
Drug Misuse	1,874	1,033
Alcohol	981	1,926
Emotional Health & Wellbeing	2,665	242
Health & Other Considerations	1,731	1,176

Table source: Watkin, Ellis & Wilson (2012) ‘Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012’ (p20)

- As can be seen from the data, most of the cases through Probation for quarter 2 scored 0 ie no issues identified, however it should be noted that Probation only score these areas as an identified issue if it has impacted on criminal activity. This is highlighted in the case of alcohol, where the number of cases where alcohol is an issue is high, which supports the custody data above which shows that 24% of detainees requiring medical treatment in custody were intoxicated on arrest”.

³⁰ Watkin, Ellis & Wilson (2012) ‘Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012’

³¹ OASys is short for Offender Assessment System. It is a national system that was developed jointly by Probation and Prisons and is now in use in its electronic version in all probation areas.

Policy links or service implications

- 3.1.14 Comparative assessment of the core NDTMS measures for offenders in the community, across the Cheshire/Warrington/Wirral service areas, should add considerably to the shared understanding of the scale of alcohol consumption and health outcomes – enabling the impacts on physical and mental health, and criminal behaviour, to be measured in more detail, to inform joined-up action planning and service commissioning (or decommissioning).
- 3.1.15 In terms of linkage with re-offending, the role of alcohol in crime and disorder is widely recognised, and as such, is a key factor in re-offending. Across the study area, a range of projects have attempted to impact on re-offending due to alcohol. For example, alcohol arrest referral schemes have been run across Cheshire custody suites, including one based in Blacon, however these have stalled due to funding cuts. CPT is currently delivering a directed intervention programme via alcohol treatment requirements, in which clients who are identified as dependent or high risk attend appropriate services. Evaluation evidence needs to be fed back to commissioners on the effectiveness of current alcohol interventions in reducing misuse and re-offending across Cheshire, Warrington and Wirral, including whether services are sufficiently 'joined up' and if there are gaps in service. Some evidence suggests that A&E data sharing and targeted interventions can reduce alcohol related disorder by around a quarter. This type of evidence needs to be presented locally.
- 3.1.16 According to World Health Organisation guidance³², evidence shows that one in eight people receiving brief intervention will change their drinking behaviour. Whilst funding is obviously spread thinly at present, it is recommended that a cost effectiveness review is undertaken to determine if alcohol arrest referral schemes can have an impact on alcohol misuse and criminality. This would be timely given the changes being implemented by Tascor to healthcare in custody suites across Cheshire – a greater focus on health promotion from May 2013 could create the right environment for alcohol arrest referral schemes to be most effective³³. National evaluation findings released in 2012 would suggest a custody setting may be worth considering again.³⁴

³² Access here: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6b.pdf

³³ Access here: <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/alcoholarrest.pdf>

³⁴ Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116267/occ102.pdf

Drug misuse

Key Facts:

- CPT statistics for 2012 reveal that across Cheshire as a whole:
 - Just over 40% of offenders were assessed as having current drug misuse problems;
 - For almost 50% of Cheshire offenders who were using drugs, this was linked to their offending behaviour;
 - Class A drug misuse was much higher proportionately amongst female offenders - female offenders had 18% higher levels injecting drugs than males, suggesting a more harmful use.
- This Chapter includes a breakdown of statistics by Local Authority area, revealing variations including:
 - Wirral has the highest proportion of offenders who are Class A misusers – of the 1129 offenders assessed as having a drug need in 2012/13, 16.3% (n = 502) were Class A misusers. In comparison, the aggregate number of offenders assessed with a drug problem who are Class A misusers across the three Cheshire study areas is 248 in total.
 - Of the four study areas, Cheshire West had the greatest proportion of offender drug misusers who were weekly users. In 2012, 36.8% of Cheshire West offenders using drugs were weekly drug users (n = 173) – a fall from 2011, when 41.8% of offenders using drugs were weekly drug users (n = 220).
- Stakeholder interviews flagged a range of issues – including inconsistencies in prison care for drug users and the vital role played by offender ‘advocates’. As is common elsewhere, local offenders with drug misuse problems often need people to proactively support them to find the right service – local treatment agencies mentioned that staff going the extra mile to support offenders would often have a massive impact.
- Offenders interviewed in treatment agencies were on the whole very positive about the recovery programmes, and the range and effectiveness of services on offer.

3.1.17 A substantial element of the interviewing for this research took place in treatment services across Cheshire, with the majority of time spent in the Crime Reduction Initiatives (CRI) Pathways service in Warrington. At this location, access to key workers, the Substance Misuse GP, strategic managers and a variety of service users was granted – providing an in-depth understanding of service delivery issues and perceptions of service effectiveness. Twelve offender interviews were undertaken with Pathways service users, including seven with those attending the Friday Cannabis Group support sessions and two with peer mentors who had only just started in post.

3.1.18 CRI Pathways is ‘an integrated drug treatment service providing a full range of treatment options to those affected by drug use whatever the drug that is being used. Service users benefit from access to wide range of other agencies that can support them on their own personal journeys of recovery’.³⁵

3.1.19 In addition to interviews in Warrington, fieldwork sought the perspectives of stakeholders and offenders on drug and alcohol misuse across Cheshire and Wirral. For example, staff and managers at Addiction Dependency Solutions (ADS) in both Northwich and Chester were interviewed, whilst several offender participants in APs and TWW had experience of either alcohol or drug recovery services. Issues relating to drug and alcohol dependency were also common

³⁵ Access here: http://cri.org.uk/sms_warrington
CheshireOffenderHNA_REPORT_June13_Final060613

threads in a range of other interviews, including the HMPYOI Styal discussion group.

What did the interviews reveal?

- 3.1.20 As would be expected given the population being studied, drug misuse was a common topic of conversation in the majority of interviews conducted. Key findings from interviews include:

Service effectiveness – CRI Pathways, Warrington

The majority of interviewees considered the quality of services experienced at CRI as very good. Only a couple had divergent viewpoints - with one having seen improvement recently in quality of support offered after what he considered a poor start to his involvement with CRI.

Several CRI interviewees commented that talking through things in an open way was a big plus for attending the Group, and having to think things through in a different way was mentioned a couple of times as examples of effective working practice - with the days exercise relating to 'personal baggage' highlighted as a good example of new ways to look at their problems.

There were very few negative comments about the recovery service, although several commented on the need to rename the CRI Cannabis Group, given that it included service users with a range of other often more complex substance misuse issues - and this led to some being uncomfortable with the mix of users, being unable to get as much from the group as they hoped as they felt reluctant or embarrassed to discuss issues that didn't relate to all round the table.

Stakeholders were very positive about the range and effectiveness of services that CRI deliver.

Lifestyle and health promotion

Offenders in the community, on the whole, aren't particularly engaged with health promotion. For drug misusers, and cannabis users in particular, smoking cessation services are in demand more than most of the health promotion services, given the psychology of addiction.

As mentioned in the Policy Context section of this report, with the drug and alcohol agenda coming through the public health outcomes framework from April 2013, it is important to 'cross-fertilise' broader public health ideas with treatment agencies - particularly to give drug users more broader public health opportunities (providing better access to trained smoking cessation expertise, for example). Proposals put forward by AP managers to further promote exercise and diet in APs, to reinvigorate health promotion activities in these hostels, was a welcome observation.

Mental health and drugs

Referral into mental health is considered quite good in Warrington, according to drug treatment staff involved in a review of mental health services in the Borough. Work is still ongoing to try to unpick some of the issues relating to dual diagnosis and unravel the cycle between drug use and mental health – exploring whether people have mental health issues because of the drugs they are using, or is it the other way round with people.

"An outreach worker was sent regularly from CRI with a peer mentor to see me. He was an ex-user, a heavy user. I was amazed to see big changes in him – so I thought 'why not me'? I'm giving back what they gave to me"
Peer mentor

PD is a conundrum to some service providers – “*is PD the primary concern or is it the substance misuse issue – sometimes people don’t treat the co-morbidity and (therefore) the whole (problem)*”.

Advocates and ‘handholding’

As is common elsewhere, local offenders with drug misuse problems often need advocates and people to proactively support them to find the right service. This has financial implications, although treatment agencies visited mentioned that staff going the extra mile to support offenders would often have a massive impact on the success of the recovery programme.

New substances and ‘legal highs’

Difficulties with mood swings was mentioned several times by offender in Cheshire East in relation to the use of a range of psychoactive substances (NPS) or ‘legal highs’ (notably Spice and Black Mamba). The May 2012 annual review of the Drug Strategy highlighted the implications of the growing use of these ‘legal highs’: “*Even though there is limited data available on these substances, there appears to have been an increase in hospital admissions and medical appointments due to the acute toxicity and adverse effects of using NPS*”.

Prison inconsistency

Consistency of care in prison is an issue flagged by several stakeholders, particularly for those who are moving around the country between establishments and also those serving short sentences followed by short periods in treatment in the community. Not having consistency has an impact on people getting well. It is a widely held belief amongst stakeholders that the service needs to be as equitable as possible. With only a small percentage of prisoners in Cheshire prisons being from the locality, this creates a conundrum for commissioners who see a large percentage of resident service users getting a completely different and inconsistent type of service in other prisons.

What do supporting statistics and assessments tell us?

3.1.21 Nationally, both the numbers and mortality rates of drug-related deaths in England and Wales fell in 2011, but noticeably both figures rose for females. 2,652 drug-related deaths were registered in England and Wales in 2011, the third consecutive year in which the figure has fallen. Deaths classified as relating to drug misuse also fell slightly, from 1784 to 1605, according to data published by the Office for National Statistics (ONS) in August 2012³⁶. Other key elements to note are:

- Despite a year-on-year fall, heroin and morphine accounted for more drug-related deaths in 2011 than any other substance, the 13th consecutive year in which this has been the case.
- Methadone was the second most-frequently mentioned substance on death certificates, followed by antidepressants.

3.1.22 Local Authority level data has been supplied by both CPT and MPT, revealing year-on-year trends in drug misuse, types of use and needs. Statistical analysis by CPT reveals that across Cheshire as a whole in 2012:

- “*40.7% of Cheshire offenders (905) were assessed as having current drug misuse problems. 14.2% (316) of offenders were Class A misusers. The largest group of Cheshire current drug misusers were using cannabis (46.1%), followed by heroin (16.3%) and Crack (12.1%).*”

³⁶Access here: http://www.ons.gov.uk/ons/dcp171778_276681.pdf
CheshireOffenderHNA_REPORT_June13_Final060613

- 37.2% of Cheshire offenders using drugs were weekly drug users (524)
- 38.6% of Cheshire offenders using drugs (630) had problems linked to their motivation to tackle drug misuse.
- For 49.4% of Cheshire offenders who were using drugs (849), this was linked to their offending behaviour.
- Class A drug misuse was much higher proportionately amongst female offenders. Female offenders had 18% higher levels injecting drugs than males, suggesting a more harmful use. The 18-20s [age group] had the lowest proportions of Class A use and the highest levels of cannabis and cocaine use. The 25-40 age group had the highest proportion and number of Crack users. The 41+ [age group] also had high levels of Heroin and Crack use”.

3.1.23 A breakdown of offender substance misuse problems by Local Authority area reveals that, between 2011 and 2012, all three Cheshire study areas witnessed increases in the percentage of offenders being assessed as having current drug misuse problems, albeit with often nominal increases in numbers. In contrast, statistics for Wirral, recently supplied by MPT for financial years 2011/12 and 2012/13, reveal that the proportion of offenders being assessed as having current drug misuse problems remained static on Wirral, with just under 37% of offenders classed as having a drug ‘need’ in both 2011/12 and 2012/13. However the volume of drug misusing offenders is considerably greater on Wirral compared to the three Cheshire study areas. The increasing number of offenders assessed with drug problems on Wirral is on the whole proportionate to the overall increase in offenders assessed between 2011/12 and 2012/13.

3.1.24 A summary of drug misuse assessment from CPT by area is included in the table on this page, followed by recently supplied data for Wirral from MPT.

Drugs Currently Misused – Cheshire study areas (CPT data)

	2012	2011
Cheshire East	<ul style="list-style-type: none"> • 40% of Cheshire East offenders (246) were assessed as having current drug misuse problems. 12.7% (78) were Class A misusers. • The largest group of Cheshire East current drug misusers were using cannabis (48.6%), followed by heroin (15.8%) and Crack (12.25%). 	<ul style="list-style-type: none"> • 30% of Cheshire East offenders (195) were assessed as having current drug misuse problems. 15.8% (103) of were Class A misusers. • The largest group of Cheshire East current drug misusers were using cannabis (38.6%), followed by heroin (20%) and Crack (15.5%).
Cheshire West	<ul style="list-style-type: none"> • 40.1% of Cheshire West offenders (297) were assessed as having current drug misuse problems. 13.7% (102) were Class A misusers. • The largest group of Cheshire West current drug misusers were using cannabis (46.8%), followed by heroin (15.4%) and Crack (12.2%). 	<ul style="list-style-type: none"> • 35.1% of Cheshire West offenders (286) were assessed as having current drug misuse problems. 16.1% (131) were Class A misusers. • The largest group of Cheshire West current drug misusers were using cannabis (48.3%), followed by heroin (19.3%) and Crack (12%).

Warrington	<ul style="list-style-type: none"> 40% of Warrington offenders (191) were assessed as having current drug misuse problems. 14.2% (68) were Class A misusers. The largest group of Warrington current drug misusers were using cannabis (42.2%), followed by heroin (18%) and Cocaine (11.7%). 	<ul style="list-style-type: none"> 33.9% of Warrington offenders (177) were assessed as having current drug misuse problems. 19% (99) were Class A misusers. The largest group of Warrington current drug misusers were using cannabis (38.4%), followed by heroin (23.6%) and Crack (12.9%).
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Table source note: Cheshire area text and statistics supplied in March 2013 taken from CPT Strategic Needs Assessments. See Appendix A5 for Local Authority level data.

Drugs Currently Misused – Wirral (MPT data)

	2012/13	2011/12
Wirral	<ul style="list-style-type: none"> 36.6% of Wirral offenders (1129) were assessed as having a current drug need. 16.3% (502) were Class A misusers. The largest group of Wirral current drug misusers were using cannabis (55%), followed by heroin (20%) and cocaine (20%). 	<ul style="list-style-type: none"> 36.7% of Wirral offenders (918) were assessed as having a current drug need. 15.4% (385) were Class A misusers. The largest group of Wirral current drug misusers were using cannabis (52%), followed by cocaine (20%) and heroin (19%).

Table source note: Statistics supplied by MPT on 30th May 2013, for 2011/12 and 2012/13. See Appendix A5 for Local Authority level data.

3.1.25 Appendix A5 reveals the range of drug misuse statistics and analyses supplied by CPT and MPT, a selection of which are presented in the following table.

	Level of Drug Use	Motivation to Tackle Drug Misuse	Drug Misuse link to Offending Behaviour
Cheshire East	In 2012, 33.9% of Cheshire East offenders using drugs were weekly drug users (133). This is similar to 2011, when 35.4% of Cheshire East offenders using drugs were weekly drug users (140).	In 2012, 41.2% of Cheshire East offenders using drugs (184) had problems linked to their motivation to tackle drug misuse. Again, this showed only marginal change from 2011.	In 2012, for 45.9% of Cheshire East offenders who were using drugs (218), this was linked to their offending behaviour. This represents a fall from 2011, when this figure stood at 51.8% (237).
Cheshire West	In 2012, 36.8% of Cheshire West offenders using drugs were weekly drug users (173) – a fall from 2011, when 41.8% of Cheshire West offenders using drugs were weekly drug users (220).	In 2012, 41.6% of Cheshire West offenders using drugs (227) had problems linked to their motivation to tackle drug misuse – a similar scale as in 2011 (42.6%, 252 in total).	For 52.6% of Cheshire West offenders who were using drugs (298) in 2012, this was linked to their offending behaviour. This was a decrease from 2011, when this equated to 54.2% (336).

Warrington	In 2012, 34.4% of Warrington offenders using drugs were weekly drug users (107) - a slight fall in numbers from 2011, when 38.5% of Warrington offenders using drugs were weekly drug users (115).	In 2012, 27.1% of Warrington offenders using drugs (96) had problems linked to their motivation to tackle drug misuse. This was a large decrease from 2011, when the figure stood at 33.9%.	For 43.9% of Warrington offenders who were using drugs (168), this was linked to their offending behaviour in 2012. This represents a slight fall from 2011, when the figure stood at 46.6%.
Wirral	In 2012/13, 23% of Wirral offenders using drugs were using them at least weekly (256) - a slight fall in the percentage of regular users from 2011/12 (26%)	In 2012/13, 74% of Wirral offenders using drugs had problems linked to their motivation to tackle drug misuse (832). This percentage had changed marginally since 2011/12 (73%)	For 85% of Wirral offenders who were using drugs (926), this was linked to their offending behaviour in 2012/13. This represents a slight increase from 2011/12 (83%).

Table source note: Cheshire area text and statistics supplied in March 2013 taken from CPT Strategic Needs Assessments, whilst statistics for Wirral supplied by MPT on 30th May 2013 for 2011/12 and 2012/13. See Appendix A5 for Local Authority level data.

3.1.26 Finally, Cheshire Probation Trusts 'Equality Act 2010 - Annual Equalities Report 2012/13' reveals that there has been a constant increase in the levels of both male and female offenders successfully completing Drug Treatment Requirements, during 2010/11. Data for 2011/12 showed that overall male and female completion rates had improved significantly with the levels of female improvement possibly due to the support from the SAFE requirement that has been put in place to address identified barriers and needs of female offenders.

3.1.27 Key points relating to drug misuse from the three most recent prison health needs assessments are replicated in the following paragraphs.

Findings from 2012 HNA for HMPYOI Styal include:

- "The most recent survey of women released from Styal found 63% used drugs whilst 39% used drugs whilst committing their index offence. Of 738 women admitted to the stabilisation unit in the year to April 2011, 546 (74%) were prescribed methadone and 19 (3%) buprenorphine but 331 (45%) of the opiate users also required alcohol detoxification and 171 (23%) women were detoxified from alcohol only. 40% of new arrivals required clinical management for drug and/or alcohol dependency. Heroin and Crack are the predominant drugs of choice". See the following table from the 2012 HNA report.

2010/11	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Heroin	64% =1	66% = 1	61% =1	56% =1
Methadone	2%	2%	2%	2%
Cocaine	4%	3%	4%	4%
Crack	13% =2	12% =2	11% =2	12% =2
Benzodiazepines	4%	3%	3%	4%
Ecstasy	1%	0%	1%	1%
Cannabis	4%	2%	3%	3%
Amphetamines	4%	3%	3%	3%
Subutex	0	0	0	0

Table source: Leigh, E. (2012) 'HMP Styal 2012 - Health Needs Assessment' (p36)

- Both CARAT³⁷ services and DIP provide support to drug users whilst in prison and facilitate access to a wide range of services upon initial release.
- Interviews conducted as part of the 2012 HNA reveal:
 - “a majority (of offenders) will work with CARATs;
 - there has been a noticed increase in Benzo use and addiction to prescription drugs;
 - 50% of mums-to-be are drug users – usually heavy users (ulcers, poor health).”
- The report identifies several inter-linked issues relating to drug misuse, including:
 - “Underlying issues behind women with mental health issues include drugs, alongside drugs and general chaos, which has led to financial and violence issues.
 - Those serving under 12 months typically have acute alcohol and drug withdrawal issues, which are linked to depression; have dental care needs (particularly long-term heroin users); have DVT associated with injecting drug use.
 - Health care staff reported that there was a perception among sentencers that sending women to prison would help them deal with their problems (e.g. drug/alcohol problems), although the reality was very different.
 - Dental health among women is worse than in the general population, due in part to oral neglect, often due to drug/alcohol problems or chaotic lifestyles of some offenders, combined with the effects on oral health of drug/alcohol use, smoking and poor nutrition”.

Findings from January 2011 HNA for HMP Risley include:

- Prisoners present with a varied mix of addictions and issues. “Risley consists of eight accommodation wings, including the Integrated Drug Treatment System (IDTS) wing. Staff indicated that HMP Risley houses an extremely diverse range of offenders, including problematic drug users, and that provision of holistic drug and alcohol treatment (and healthcare treatment) for such a diverse population represented complex challenges. As at October 2010, 16.4% (N=178) of offenders in HMP Risley were imprisoned for committing a drugs offence”. See the table that follows, taken from the 2011 HNA.

<i>Offence</i>	<i>Number of Prisoners</i>	<i>Percent (%)</i>
Burglary	114	10.5
Robbery	164	15.1
Theft & Handling	15	1.4
Fraud & Forgery	11	1.0
Drugs Offences	178	16.4
Violence Against the Person	244	22.5
Other Offences	101	9.3
Sexual Offences	75	6.9
Offence not Recorded or Holding Warrant	182	16.8
<i>Total</i>	<i>1,084</i>	<i>100</i>

Table source: Russell, S and Jones, L (January 2011) ‘Healthcare Needs Assessment HMP Risley’. Liverpool JMU Centre for Public Health (p24)

³⁷ CARAT (Counselling Assessment Referral Advice & Throughcare) is a drug service available in every prison in the UK
 CheshireOffenderHNA_REPORT_June13_Final060613

- Since publication of the 2011 HNA the drug and alcohol service has been re-commissioned, however at the time of the HNA fieldwork prisoners did not have positive views on the service: *“Forty-three percent of the 134 participants who completed the HNA offender questionnaire (N=53) reported overall drug and alcohol services to be poor or very poor”*.
- Other findings relating to the drug service at the time include:
 - *“Staff reported that health promotion initiatives at HMP Risley were guided and coincided with the NHS calendar and had recently included awareness sessions for alcohol use. Drug Awareness-Level 1 is one of the Social and Life Skills available for offenders.*
 - *Screening processes for HIV and Hepatitis B and C were reported to be comprehensive and confidential. While screening was not compulsory, and generally led by the offender, staff indicated that if an individual indicated past injecting of drugs or other risky behaviours, they would be strongly encouraged to participate in the screening processes for hepatitis and HIV. Healthcare staff identified treatment of hepatitis as a gap in drug related service provision.*
 - *Drug testing teams reported particularly good link up with IDTS nurses and indicated that close communication was very important in order to inform staff about patterns of substance use among offenders and to check whether positive tests were due to prescribed medication.*
 - *Prison Officers described how BME offenders were less likely to engage with services, especially for drug treatment, but were unsure why.... there may be a heightened stigma among BME offenders (among their families and in the community) surrounding drug use, which could create a barrier to accessing drug treatment services”*.

Findings from January 2011 HNA for HMPYOI Thorn Cross include:

- In late 2010, when the HNA fieldwork was undertaken, there were: *“290 prisoners detained in HMPYOI Thorn Cross...the most common offences recorded for this cohort of offenders were for violence (24.5%), drug offences (24.0%), and robbery (23.5%)”*. See table that follows, taken from the 2011 HNA.

<i>Offence</i>	<i>Unit 1</i>	<i>Unit 2</i>	<i>Unit 3</i>	<i>Unit 4</i>	<i>Unit 5</i>	<i>Total</i>	<i>Percent (%)</i>
Burglary	5	8	3	9	7	32	11.0
Violence	13	19	10	13	16	71	24.5
Robbery	15	20	12	8	13	68	23.5
Theft/HSG	3	1	3	1	1	9	3.0
Death by driving	3	1	1	2	-	7	2.5
Other Driving Offences	3	-	-	1	-	4	1.5
Drugs	12	6	22	18	12	70	24.0
Possession of Firearm/Weapon	2	6	3	2	2	11	4.0
Violent Disorder	-	-	-	-	-	-	-
Breaches	2	1	2	3	-	8	3.0
Other	2	2	2	2	2	10	3.5
<i>Total</i>	<i>60</i>	<i>60</i>	<i>58</i>	<i>59</i>	<i>53</i>	<i>290</i>	<i>100</i>

Table source: Russell, S and Jones, L (January 2011) ‘Healthcare Needs Assessment HMYOI Thorn Cross’. Liverpool JMU Centre for Public Health (p22)

- Other findings relating to the drug service at the time include:
 - *“Healthcare services (including drug treatment services) were found to be well integrated and better than would be available in a community setting.*
 - *Unit One holds young adult offenders aged between 18 and 25 years; Unit Two, which also functions as the Mandatory Drug Testing (MDT) unit also holds young adults aged between 18 and 25 years; Unit Three, the induction unit, houses adult offenders aged between 21 and 25 years; Unit Four also holds young adult offenders aged between 21 and 25 years; and Unit Five, the High Intensity Training (HIT) centre, holds young offenders between the ages of 18 and 21 years³⁸.*
 - *Interviewees reported that staff had adequate resources and equipment to effectively deliver prison healthcare services, including drug treatment services.*
 - *Staff described offenders to be a relatively homogenous population but that often within the population there would be several vulnerable individuals, who may have been problematic drug users, dependent drinkers or suffered adversely from mental health conditions.*
 - *Staff indicated that if an individual indicated past injecting of drugs or other risky behaviour, they would be strongly encouraged to participate in screening processes for HIV and hepatitis.*
 - *Gym and physical education (PE) was popular amongst offenders, and a referral option for drug users. PE was reported to be voluntary, but referrals were made from the GP, healthcare staff, CARATs or prison officers for rehabilitative PE, weight management, risk of self harm, low self esteem or to tackle drug use”.*

- Release plan data collected for the HNA was, unfortunately, sketchy in relation to referrals to DIP or other drug services. *“From March 2009 to April 2010 a total of 217 release plans were completed by CARAT staff at HMPYOI Thorn Cross; a total of 114 transfer plans were sent from HMPYOI Thorn Cross to other prisons; and 241 transfer plans were received by HMPYOI Thorn Cross from other prisons”.* See table that follows

“There are a lot of young men who drink and take drugs. We will breach confidentiality if there is threat of absconding, risk to themselves or risk to others; its case by case, if they are smoking cannabis for example, we wouldn't breach confidentiality”
 Staff quote, taken from 2011 HNA report

Release planning	Number of prisoners (N)
Release Plans	217
Transfer Plans (sent from HMYOI Thorn Cross to other prisons)	114
Transfer Plans (received from other prisons)	241
Referred to DIP	Data unavailable
Referred to other services e.g. Alcohol and Drug Service	Data unavailable

Table source: Russell, S and Jones, L (January 2011) ‘Healthcare Needs Assessment HMYOI Thorn Cross’. Liverpool JMU Centre for Public Health (p36)

³⁸ Note: since publication of this HNA, the age profile of the offenders has changed, with approximately a quarter being over 25 years of age at the time of writing
 CheshireOffenderHNA_REPORT_June13_Final060613

- Offenders interviewed reported very few problems with the prison regime – *“it was broadly suggested that being an open prison enabled good cross team link up and flexibility in terms of scheduling appointments for drug services or healthcare”*.
- In terms of links between drug use and mental health, *“staff also suggested that mental health problems also occurred among drug users for whom previous drug use may have either caused a condition or masked an underlying issue. Most common mental health complaints were not severe and mostly arose from a lack of contact with family members or previous drug use”*.
- Low drug use among offenders was cited as one of the primary reasons why all individuals received a satisfactory and equal level of care

Findings from 2012 HNA for Cheshire Custody Suites

3.1.28 Finally, as well as drug misuse information gathered from Probation OASys and the perspectives from prisons, the prevalence and impact of drug misuse is assessed through the lens of those working in custody suites. The 2012 HNA for the Cheshire custody suites notes that:

- *“Drug misuse in the county (10 per 1,000 resident population aged 15-64) is higher than the national average (9.4) but still lower than the North West average.*
- *Data collected in October 2011 [for the Cheshire custody suite HNA] shows that it is largely not known if detained persons have issues with drugs, although it is shown that Heroin and Cannabis use is high for those detainees who admit to drug use. Blacon Custody Suite has the highest number of Heroin users for the Cheshire area, with Runcorn worse affected for Cannabis and Cocaine use.*
- *Based on the records reviewed in police custody, it is shown that those detained persons who present at custody who admit to drug use do not appear to be in contact with drug services to obtain support for their problem, however this could be the Provider not collating this information”*. The breakdown of drug use data is shown in the table that follows:

Custody Suite	No of persons detained and seen by Reliance Medical Services in the period 1 st – 31 st October 2011 with Drug issues based on a 10% sample of records						
	Heroin	Cannabis	Cocaine	Other	None	Not Known	In contact with Drug Services
Blacon	3	3	1	3	5	9	0
Middlewich	1	2	0	0	6	17	0
Runcorn	1	3	3	0	13	6	0
Total	5	8	4	3	24	32	0

Table source: Watkin, Ellis & Wilson (2012) ‘Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012’ (p16)

- *“It is understood from Cheshire Drug and Alcohol Team that Blacon, Middlewich and Runcorn custody suites operate a drug arrest referral service, Drug Intervention Programme (DiP) workers regularly visit the custody facilities to speak with detainees who may need support for their*

drug issues. The aim of the service is to direct detainees into treatment where the need arises, or to work with them to reduce their offending. They are commissioned with a KPI to achieve 95% of clients on the caseload to be referred into structured treatment. In Quarter 1 and Quarter 2 of 2011 they have achieved 100% and 97% respectively. The DIP will also case manage appropriate PPO's³⁹ or repeat offenders and give brief interventions to alcohol clients who are subject to a conditional caution.

- Recommendations made in the report for service development include:
 - “to ensure referrals are made to services where this is warranted, with more partnership working to be encouraged between all agencies⁴⁰”.
 - to introduce a comprehensive health screening tool to be completed by the custody nurse for detainees, not just those who require medical treatment, to ascertain what health needs there may be and to refer to the appropriate services if required. This is aspirational and will require negotiation with the Healthcare Provider”.

Policy links or service implications

3.1.29 The NTA publication ‘Estimating the crime reduction benefits of drug treatment and recovery’ reveals that “drug related crime costs £13.9bn per year and that offenders who use heroin, cocaine or crack cocaine commit between a third and a half of all acquisitive crimes⁴¹. Their estimate is that drug treatment and recovery systems in England may have prevented approximately 4.9m crimes in 2010-11, with an estimated saving to society of £960m in costs to the public, businesses, the CJS and NHS.

3.1.30 Statistics reveal that newly released male and female prisoners are at acute risk of drug-related death⁴². Therefore recovery services that go ‘through the gate’ to offer initial support to substance misusers, proactively coach offenders to set in place essential health structures (such as GP registration) and then continue to offer assistance during recovery programmes, should not be under-valued.

3.1.31 CRI Pathways in Warrington is an example of a recovery service that provides that essential platform for offenders as they enter or re-enter the community. Interviews with service users were almost entirely complimentary on the role that Pathway services are playing in their attempts to remove or reduce substance dependency from their lives. It is important to evaluate the effectiveness of current drug and alcohol interventions in reducing misuse and re-offending across the Cheshire area footprint and communicate lessons learnt to commissioners in the relevant CJS and health agencies.

³⁹ Prolific and priority offenders (PPOs) are persistent offenders who pose the greatest threat to the safety and confidence of their community.

⁴⁰ Note: this is a cornerstone of the new Tascor contract

⁴¹ Access here: <http://www.nta.nhs.uk/uploads/vfm2012.pdf>

⁴² Access here: [http://www.ihra.net/files/2010/08/23/Farrell - Acute Risk of Drug-Related Death \(Prisoners\).pdf](http://www.ihra.net/files/2010/08/23/Farrell - Acute Risk of Drug-Related Death (Prisoners).pdf)

3.2 Mental health and learning disabilities

Key Facts:

- National statistics on offender mental health problems are bleak: more than 70% of the prison population has two or more mental health disorders, whilst female prisoners are 35 times more likely to have two or more disorders than women in general; Ex-prisoners are at greatest risk of suicide in the period immediately following release. Among ex-offenders, women have a 36-fold increased suicide risk while male ex-offenders have an eight fold increased risk.
- CPT and MPT statistics reveal that:
 - Across Cheshire as a whole in 2012, a far greater percentage of female offenders had current psychological needs (67.2% compared to 36.8% of males), higher self-harm/suicide attempt problems (44.7% for females against 26.7% for males) and higher current psychiatric needs (26.7% against 15.25 for males).
 - The most common mental health illnesses amongst Cheshire East, Cheshire West and Warrington offenders were depression and anxiety.
 - On Wirral, there are a significant number of offenders being assessed with an emotional well-being need. In 2012/13, 1832 offenders were assessed with this type of need, representing 59.4% of all offenders.
- PD is a common area of concern across all of the geographical areas and stakeholders. Since the fieldwork, CPT has secured funding for specialist PD support in Cheshire East and Cheshire West, which will hopefully provide a valuable additional resource in those areas.
- Those with learning disabilities who engage in offending behaviour often have complex needs and are often subject to exclusion from both mainstream and specialist services. A third of women at HMPYOI Styal have a learning disability – and the resourcing of services for this cohort was flagged as a priority by the Styal discussion group during fieldwork.

3.2.1 To clarify at the outset, this report is using the phrase ‘mental health problem’ as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including PD.

3.2.2 The prevalence of mental health problems or disorders varies across offender cohorts. For example, the evidence base⁴³ that was published alongside the ‘No health without mental health’ strategy in February 2011, highlights that:

- *“More than 70% of the prison population has two or more mental health disorders. Female prisoners are 35 times more likely to have two or more disorders than women in general.*
- *Female prisoners also have a 20-fold increased risk of suicide, while males in prisons are at five times higher risk, compared to general population.*
- *Ex-prisoners were at greatest risk of suicide in the period immediately following release. Among ex-offenders, women have a 36 -fold increased suicide risk (SMR 35.8) while male ex-offenders have an 8 fold increased risk (SMR 8.3).”*

3.2.3 Though mental health specialists were not directly targeted for engagement as part of this study, the significance of mental health problems and disorders was stressed in a considerable number of stakeholder interviews. Some of the key themes and topics for discussion follow.

⁴³ Access here: <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

What did the interviews reveal?

3.2.4 The summary matrix of offender characteristics, in Appendix A1, reveals that 11 of the 33 offenders interviewed cited mental health problems as being areas of concern to them that affected their day-to-day lives. The range of mental health issues ranged from schizophrenia through to anxiety and paranoia. Of the seven women interviewed, it is worth noting that four highlighted mental health conditions.

“There are more CPN specialists around now – previously Halton had a mental health CPN and Warrington the Revolving Doors project, so it felt that there was a differential level of resource dependant on where you were, but its now more level”

Cheshire
Probation
Trust strategic
manager

3.2.5 Themes that emerged from stakeholder and offender interviews when discussing mental health include:

PD as a common area of concern

PD concerns span across the agencies and settings. For example:

- Within Wirral Probation, PD was described as a significant problem that meant it was hard for offender managers to manage individuals. In addition, PD coupled with ADHD was cited as a major reason for the failure of many young people to complete community sentences and accredited programmes, affecting the ability of individuals to stay focused at critical times.
- In the HMP Styal HNA published in 2012, a review of issues affecting the offender management unit found that *“Personality Disorder seems to be a concern – it is difficult for the team to get psychological input; however staff would go to Mental Health In-Reach and ask them to assess if there was significant concerns”*.

Its important to have adequate staffing expertise and consistent support systems in place across Cheshire and Merseyside to cater for PD, as research suggests PD is more likely to be present in offenders that:

- *“end up being recalled to prison;*
- *accumulate adjudications;*
- *breach hostel rules;*
- *drop out of or fail to make progress in accredited programmes;*
- *make complaints about staff;*
- *self-harm;*
- *are transferred to secure NHS settings; and*
- *cause staff to go off sick” [for example, through stress caused by not being able to deal with PD].⁴⁴*

Staff training and expertise

Interviews in the APs revealed several concerns relating to the demands associated with resident’s mental health. Where someone is diagnosed with severe and enduring mental illness (such as a psychotic condition), the assessment and referral service is generally considered good. However with regard to PD in particular, the psychiatric assessment and referral process is considered very slow and inadequate by staff. This was considered an area where there is a gap and a potential risk to residents and staff alike, considering that *“there are only two operational staff on duty each day who don’t have specialist training”*.

Since the fieldwork interviews with AP staff, CPT has secured funding for specialist PD support in Cheshire East and Cheshire West, which will hopefully cascade expertise and support. In addition, two members of Probation staff are completing specialist MSc qualifications in this field. Elsewhere in Cheshire,

⁴⁴ Introduction of ‘Working with personality disordered offenders: A practitioners guide’ (Jan 2011). Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147482/dh_124319.pdf
CheshireOffenderHNA_REPORT_June13_Final060613 Page 41 of 82

“The nature of risk remains relatively stable, but the most high risk cases tend to be the personality disorder offenders - usually anti-social stuff, the anti-social clusters”
Probation officer

Warrington stakeholders have noted how access to Knowledge and Understanding Framework (KUF) PD Awareness training⁴⁵ has supported them to deliver high quality effective care to people who have a PD.

Perceived gaps in HMPYOI Styal mental health resources

The six staff involved in the HMPYOI Styal discussion group were asked which three areas were priorities for improvement – and better mental health provision was flagged, alongside improvements to alcohol services and more resources to cope with learning difficulties.

Waiting times

There are issues around being discharged from prison and not being motivated to engage with support services, and part of the explanation for lack of engagement is how people are communicated with. When people referred to drugs services or refer themselves, a contact is classed in some cases as being offered a telephone number. But often those with the worst mental health issues are in chaotic lifestyles and rarely make the calls. As a Probation manager noted *“this conceals the true nature on what is going on (in the community). The real picture tends to emerge when they get to the stage of custodial sentencing.”*

In terms of getting people into the system, Probation staff highlighted that there are considerable waiting times in some areas of Cheshire. This was deteriorating, and was a reflection of public sector spending cuts.

Learning disabilities

The HMPYOI Styal discussion group highlighted the under-resourcing of services for female offenders with learning disabilities as an area of concern. Probation staff noted gaps in the services they can provide regarding learning disabilities, with one noting that *“learning disability team referral was difficult to access (provision for autistic spectrum stuff) as people fall between two stools, as a lot of issues co-exist, resulting in offenders being passed round in circles”*.

What do supporting statistics and assessments tell us?

3.2.6 Statistics from the 2012 CPT strategic assessment reveal that across Cheshire as a whole:

- 59.1% of Cheshire offenders had coping difficulties (1152).
- 32.6% of offenders (636) had problems with social isolation.
- 41% of offenders had current psychological needs (800).
- 30.9% had disclosed or been assessed with problems with self-harm or suicide attempts (602).
- Women offenders had strikingly higher proportions of coping difficulties (81.2% against 55% for men). This is a consistent finding nationally. Higher age-bands had much greater levels of coping problems, with the highest percentage identifying a coping difficulty being in the over forty years of age cohort (67.8%). A large percentage of disabled offenders also had coping difficulties (79.3%).
- A far larger percentage of female offenders had current psychological needs (67.2% compared to 36.8% of males), higher self-harm/suicide attempt problems (44.7% for females against 26.7% for males) and higher current psychiatric needs (26.7% against 15.25 for males).
- Social isolation problems were much higher for women (56%), disabled offenders (46.8%) and age 41+ offenders (42.1%).

⁴⁵ Access here: <http://www.5boroughpartnership.nhs.uk/involvement-and-working-together/>
CheshireOffenderHNA_REPORT_June13_Final060613

- 35.5% of Cheshire offenders were assessed as having a disability. The most common disabilities in Cheshire offenders were linked to depression, reduced mobility and reduced physical capacity. The most common mental health problems including ADHD⁴⁶, Bipolar and Schizophrenia were also evident but in much smaller numbers.

3.2.7 Localised Probation statistics relating to mental health and disabilities, for Warrington, Cheshire East, Cheshire West and Wirral are included in Appendix A5. A selection of comparable statistics from CPT is included in the table that follows, for the three Cheshire study areas:

CPT disability assessment

	2012	2011
Cheshire East	<i>“40.6% of Cheshire East offenders were assessed as having a disability. The most common disabilities were linked to depression, reduced mobility & reduced physical capacity. The most common mental health illnesses amongst Cheshire East offenders were depression, ‘unknown’ mental condition and anxiety. ADHD, personality disorder and Bipolar were also evident but in much smaller numbers”.</i>	<i>“23.1% of Cheshire East offenders were assessed as having a disability. This may well underestimate the total. The most common disabilities in offenders were linked to depression, reduced mobility & anxiety. The most common mental health illnesses were depression & anxiety. Post-traumatic Stress, Psychosis, ADHD & Schizophrenia were also evident but in much smaller numbers”.</i>
Cheshire West	<i>“33.6% of Cheshire West offenders were assessed as having a disability. The most common disabilities were linked to depression, reduced mobility & anxiety. The most common mental health illnesses amongst Cheshire West offenders were depression and anxiety. ADHD, and Schizophrenia were also evident but in much smaller numbers”.</i>	<i>“17.7% of Cheshire West offenders were assessed as having a disability. This may well underestimate the total. The most common disabilities were linked to depression, reduced mobility & anxiety. The most common mental health illnesses were depression & anxiety. Post-traumatic Stress, Psychosis, ADHD & Schizophrenia were also evident but in much smaller numbers”.</i>
Warrington	<i>“35.5% of Warrington offenders were assessed as having a disability. The most common disabilities were linked to depression, reduced physical capacity and reduced mobility. The most common mental health illnesses were depression, anxiety and ADHD. Schizophrenia, Bipolar and personality disorders were also evident but in much smaller numbers”.</i>	<i>“18.3% of Warrington offenders were assessed as having a disability. This may well underestimate the total. The most common disabilities were linked to depression, reduced mobility and anxiety. The most common mental health illnesses were depression and anxiety. Post-traumatic Stress, Psychosis, ADHD & Schizophrenia were also evident but in much smaller numbers”.</i>

Table source note: Text and statistics taken from CPT Strategic Needs Assessments. See Appendix A5 for Local Authority level data.

⁴⁶ ADHD = Attention deficit-hyperactivity disorder, is a mental disorder and neurobehavioral disorder characterised by either significant difficulties of inattention or hyperactivity and impulsiveness or a combination of the two.

- 3.2.8 Data tables for Wirral, supplied in May 2013 by MPT, provide less detail on the prevalence of mental health conditions and disabilities compared to the statistical analyses provided by CPT – see Appendix A5. However it is evident from the headline Wirral statistics that:
- There is a significant number of offenders being assessed with an emotional well-being need. In 2012/13 1832 offenders were assessed with this type of need, representing 59.4% of all offenders assessed on Wirral.
 - The number of Wirral offenders being assessed as having problems with self-harm or suicide attempts has increased marginally in recent years – 18.8% of all offenders assessed in 2012/13 had this problem, compared to 17.5% the year before. 578 offenders in 2012/13 were assessed with this need.
- 3.2.9 Key findings relating to mental health problems, taken from the three most recent local prison HNAs and the 2012 Cheshire Custody Suite HNA, are quoted in the remaining paragraphs of this section of the report.

Findings from 2012 HNA for HMPYOI Styal include:

- *“The most recent survey of women released from Styal found a high percentage have a diagnosed mental health problems (50%), whilst about 20% have previous contact with psychiatric services”.*
- Key facts presented on mental health in HMP Styal are:
 - *“Approximately 85 women are on the current Mental Health caseload (this does not include those receiving support from elsewhere).*
 - *Over 50% of women entering HMP Styal state that they have emotional wellbeing and mental health issues.*
 - *There is a significant cohort of women who have a Personality Disorder.*
 - *There is a gap in service provision for women with common mental health problems such as anxiety and depression.*
 - *The overall number of women who self-harmed had reduced from 210 in 2009 to 101 in 2010”.*
- The percentage of women experiencing mental health disorders is revealed in the table that follows, taken from the 2012 report:

	Those on Remand	Sentenced Women
Those with anxiety and depression	36%	31%
Suicidal thoughts in the last week	23%	8%
Suffering from two or more mental disorder	70%	
Suffering from a psychotic disorder	14%	

Table source: Leigh, E. (2012) ‘HMP Styal 2012 - Health Needs Assessment’ (p30)

- *“There had been 27 transfers under the Mental Health Act between April 2010 and June 2011, of which 19 had waited longer than two weeks. The longest wait for assessment and transfer had been about five months.*
- *Since the last HNA in 2009 an outstanding action remains around sharing learning opportunities with Prison Service staff (particularly around supporting mental health and wellbeing).*

- *Underlying issues behind women with mental health issues include drugs, alongside drugs and general chaos, which has led to financial and violence issues*
- *Approximately 1 in 10 women entering HMP Styal have an IQ of less than 70. A third of women at HMP Styal have a learning disability”.*

Findings from January 2011 HNA for HMP Risley include:

- *“HMP Risley houses a broad diversity of individuals with a range of physical and mental health problems, some of which require continued specialist treatment.*
- *In June 2009 the Independent Monitoring Board (IMB) reported that the standard of care provided at HMP Risley was very good and that most services were provided comparatively to those in the community. The main concern raised by the IMB was the continued need for improved service provision for prisoners with mental health issues, especially those at risk of self-harm or suicidal ideation. HMP Risley has introduced a peer support scheme comprising of Peer Listeners in order to meet a key recommendation of the HM Inspectorate Report (2008).*
- *Questionnaire participants generally reported their perceived health to be good; The most frequently reported mental health problems were depression (21.9%), stress (15.3%) and anxiety (10.9%).*
- *Offenders typically expressed greater concern about their mental rather than their physical health and generally suggested that mental health problems were not addressed as comprehensively as physical health problems.*
- *Of the relatively small sample of offenders interviewed the following mental health conditions were reported; depression, anxiety, stress, panic attacks and psychotic disorders (including schizophrenic conditions, such as multiple personality disorder, delusional disorders and hallucinations).*
- *Mental health services were reported to be well functioning, providing for a diverse array of mental health conditions, which were often accompanied with physical health problems and/or substance use. The mental health team was reported to link well with mainstream healthcare and pharmacy, particularly with regards to pain management and prescribing. Monitoring and follow up work was reported to be well functioning, however several staff and offenders reported that a substantial proportion of offenders suffered from adverse mental health complaints but that not all offenders were comfortable engaging with services and discussing their problems; for such problems a proactive and multi-disciplinary approach across teams would be recommended.*
- *There may also be consideration of the introduction of non-medical based treatments in keeping with their increasingly widespread use in community settings; such treatments may include psychological based approaches. Primary care services may also be able to help identify those at risk or “poor copers” and employ coping strategies, such as “talking therapies”, administered by appropriately trained staff. Provision of wing-based services may also help address these problems; such wing-based provision may require effective mental health awareness training for wing officers with the aim that they might develop the competencies and confidence to identify the early signs of mental health issues and advise on appropriate support.*

- *The opposite problem was also described by some staff, in that several offenders engaged with mental health services were mentally well but enjoyed and benefited from sessions and did not want to be signed off from the caseload. In these instances continued monitoring and assessment would help identify such examples, which may be coupled with the recommendation to a purposeful activity, such as additional gym time or a different job”.*
- Recommendations for service development in the 2011 report include:
 - *“Improving and developing provision for mental health disorders, especially for younger offenders, who may be experiencing closed condition prison for the first time. In addition to the improved monitoring of offenders, further interventions may be developed that are proactive, discrete, persistent and integrated. These interventions would be maximised if consistently undertaken by a multi-disciplinary approach involving Prison Officers, CARAT workers, healthcare nurses and the Mental Health Team.*
 - *Consider work to pilot and evaluate a pro-active approach to engage offenders with mental health disorders, including training for Prison Officers to act as a wing-based support service. Such an initiative may be targeted at younger offenders, new arrivals and those offenders who have been imprisoned for the first time”.*

Findings from January 2011 HNA for HMPYOI Thorn Cross include:

- *“Staff described offenders to be a relatively homogenous population but that often within the population there would be several vulnerable individuals, who may have ... suffered adversely from mental health conditions.*
- *The general physical and mental health of offenders at HMPYOI Thorn Cross was reported to be very good.... the most common mental health problems were reported to be stress, anxiety and depression.[When asked about their health problems, 13.4% reported stress, 10.4% reported anxiety, 7.5% reported ADHD, 6.0% reported depression and 4.5% reported paranoia].*
- *A substantial proportion of offenders indicated that they had suffered adverse mental health problems at some time while imprisoned at HMPYOI Thorn Cross but expressed hesitancy to engage with appropriate services.*
- *Mental health services were reported to be well functioning but some staff reported that a stigma existed among some offenders about reporting mental health issues or conditions to the mental health team. While the vast majority of mental health problems were not reported to be complex, a substantial proportion of offenders reported feeling anxious, stressed or depressed at some time during their period of incarceration at HMPYOI Thorn Cross”.*
- Recommendations for service development in the 2011 report include:
 - *“To improve access to mental health services by addressing the stigma associated with mental health conditions among offenders. Appropriate service enhancement may include the development of a proactive and multi-disciplinary approach to engaging offenders through the development of wing-based services, especially for those who are relatively young, are new to the prison or who have a history of substance use or mental health problems.*
 - *Such a proactive approach may include specialist mental health awareness training for selected Prison Officers to create a mobile and*

constant monitoring and assessment tool. Approaches to promoting mental health should consider the important role that family and friends play in providing support to offenders.

- Appraise the screening of mental health conditions, especially for those who are young or who have been imprisoned for the first time. Consideration should be given to the use of pro-active techniques, including specialist mental health awareness training for selected Prison Officers, in an attempt to address mental health conditions among young offenders, especially among those who may be reluctant to engage with prison services”.

Findings from 2012 HNA for Cheshire Custody Suites

3.2.10 Finally, the Cheshire Custody Suite HNA highlights the following mental health issues for detainees:

- “Hospital stays for self harm are higher in all five boroughs in Cheshire than the England average (198.3 DSR per 100,000 population), with only Warrington (252.1) having a rate lower than the North West average (263.2). This reflects the higher admission rates for mental health related problems.
- From the records reviewed:
 - The number of detainees where it is not known if there are any mental health issues is high.
 - However, where mental health problems have been identified the number of detainees who have a history of or currently suffer from depression is high, particularly in Middlewich and Runcorn custody areas.
 - It should be noted that 47% of those who stated depression when asked about mental health issues also informed of a history of self harm. With 879 and 774 hospital stays for self harm per 100,000 population in Cheshire East and Cheshire West & Chester respectively these are problematic areas as they are significantly higher than the national averages.
- Once again, the number of detainees who are in contact with mental health services for an identified problem is low at just 12%”.
- The breakdown of mental health issues is revealed in the table below, taken from the 2012 report:

Custody Suite	No of persons detained and seen by Reliance Medical Services in the period 1 st – 31 st October 2011 with Mental Health issues based on a 10% sample of records					
	Depression	Anxiety	Self Harm	Other (ie Psychosis, Schizophrenia)	Not Known	In contact with Mental Health Services
Blacon	8	2	3	3	8	4
Middlewich	12	2	0	1	11	1
Runcorn	14	1	3	1	7	1
Total	34	5	6	5	26	6

Table source: Watkin, Ellis & Wilson (2012) ‘Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012’ (p17)

- A recommendation made in the 2012 HNA relating to mental health is “to ensure referrals to the correct service for a mental health assessment / ongoing intervention are made for those with an identified mental health problem and to encourage more robust partnership working with agencies”.

Policy links or service implications

3.2.11 In their response to the Ministry of Justice consultation paper on 'Transforming Rehabilitation', Cheshire Probation Trust (CPT) state: *"that the fragmentation of offender management and a plurality of providers can result in offenders with complex needs, including personality disorder, mental health problems and learning disabilities falling through a gap in terms of service delivery"*⁴⁷.

3.2.12 Building upon several of the practical steps suggested in the 2012 'No health without mental health: implementation framework', it is recommended that all agencies involved with offenders in the community should:

'Mental health issues can have a destabilising affect and those with serious mental health problems are more likely to fail on supervision. Ensuring individuals gain access to appropriate health services and to support services such as benefits, supported accommodation and registering with a GP is therefore particularly important for this group'
NOMS
Commissioning Intentions for 2013-14

- Review and develop staff awareness of mental health issues where gaps exist, ensuring that staff have attended appropriate, evidence-based awareness training and have access to relevant guidance and information. Sharing knowledge across agencies is critical.
- Evaluate present diversion routes, working with Probation, Youth Offending Teams, mental health services, and liaison/diversion services to map and critically assess. Strong partnerships are crucial for timely identification of needs and effective joint working for the duration of a sentence, for the use of the mental health treatment requirement, and as a means of diverting offenders from the criminal justice system or from custody where appropriate.
- All three Cheshire prisons should ensure that offenders with mental health problems are identified as soon as possible, and given appropriate support. This includes suitable access to health services and rehabilitation services offered within the prison, or externally where necessary, both for prisoners with common mental health problems and those with more specialist needs, including PD. Areas of concern flagged by HMPYOI Styal staff members need to be investigated in more depth. New services commissioned from April 2013 should contribute to continuing service improvement efforts, including a service to address psychological needs of women provided by Greater Manchester West Mental Health NHS Foundation Trust.
- Custody suites can play an important role in identifying offenders with mental health issues. Though attending often for short periods at a time, offenders are often at crisis point and sometimes reaching a 'learning moment' when they are susceptible to offers of help. Close liaison between Tascor healthcare staff and police officers will improve early identification of problems, and staff should be 'upskilled' in some areas to be aware of the support available to them to help identify potential mental health problems and deal with known issues.

3.2.13 PD is a recognised mental disorder, and an issue that has been mentioned as a concern for stakeholders time and time again in interviews. Studies have estimated that it affects between 4% and 11% of the UK population and between 60% and 70% of people in prison. Until recently PD was neglected by services and often regarded as untreatable. However, NICE has published guidance on management and treatment and, gradually, more services are recognising and catering for this disorder. This study highlights PD as an area of offender service support that needs far greater resource. Stakeholders report that CPT has recently won grant funding with partners in Cheshire East and Cheshire West to target this specific area of need, which is a positive development in this specific part of the study area. Yet it is apparent that more PD service funding, commissioning and provision is needed across the entire study area.

⁴⁷ Access here: http://www.cheshireprobation.org.uk/files/publications/document_275.doc
CheshireOffenderHNA_REPORT_June13_Final060613

3.3 Access to healthcare and role of GPs

Key Facts:

- A surprisingly high number of offenders interviewed during fieldwork (24 of the 33) were registered with a GP, thanks largely to advocates in treatment agencies and other service providers supporting them in the registration process as soon as possible on return to the community.
- However, access issues relating to primary care persist, often caused by a lack of understanding about offenders' behaviour - both from the perspective of the offender (not appreciating how their aggressive, uncommunicative behaviour creates problems) and also the healthcare staff they come into contact with.
- As well as the barriers to healthcare, stakeholder interviews highlighted a range of quality services available to offenders, depending on their community sentence. For example, the residents of Cheshire APs have access to 'a silver service' from GPs visiting them weekly.
- Offenders interviewed were on the whole very positive about access to healthcare – particularly in APs and the women's centre at TWW.

What did the interviews reveal?

3.3.1 To the surprise of the researcher, most of the offenders interviewed were registered with a local GP surgery. The matrix of key characteristics included in Appendix A1 reveals that 24 of the 33 interviewed had access to a GP. However, further investigation reveals that many of those interviewed had been supported or even had registration stipulated as part of their access to services – including as a precursor to accessing services at treatment agencies, for example. Stakeholders across a range of agencies flagged the importance of registration as a critical first step in moving offenders along an 'engagement continuum'.

3.3.2 On face value, therefore, access to primary care does not appear much of a problem. It is well documented that successful resettlement into the community is more likely if prisoners with health problems have support in overcoming interconnected barriers in areas such as access to housing and primary care. Primary healthcare can often be a gateway to other services, and so registering with a GP can have wide-ranging consequences when things work well. Yet stakeholders and offenders identified a number of process failure points that can undermine how successful offender health outcomes can be achieved, both with GP surgeries and other healthcare settings, including:

Understanding and stigma

Issues regarding stigma of offenders was raised several times by a variety of stakeholders – including GPs themselves and key workers in APs. In Chapter 3.6, the needs of residents in APs are documented in more detail. Issues flagged by staff working there include:

- GPs who had experience of offender behaviour in both custody and the community were considered far more likely to have good relationships with a patient and stakeholders supporting the offender;
- Some surgery receptionists were considered 'difficult' by Probation staff, answering calls and queries relating to an offenders health with "*disdain, as though these people were a nuisance*".
- Several Probation staff also highlighted the difficulties they had experienced with some GPs, notably when it came to writing a 'sick note'

"They want everything now! Which frustrates a lot of staff. But conversely they're not given a chance often – some GPs just hand out prescriptions to get them out quickly, to keep them quiet or in some cases because they're intimidated"
GP

without a thorough diagnostic of the offender and not understanding how that impacted on their work with offenders.

Improving communication and understanding between GPs, surgery receptionists and other key stakeholders (for example, Probation staff) is essential to ensure offenders effectively engage with support structures.

It was also noted by one stakeholder that people in the broader healthcare spectrum also need to develop a practical understanding about drug misusing people – *“they’re not always going into Boots ‘on the rob’, they’re going in for their script”*.

Access – barriers and privilege

Sometimes stigma or even discrimination can have practical implications for the recovery programme of an offender. Cases were given where, on occasion, offenders could not get access to pharmacies, or else were told to stand by the door and not to touch anything. The measures that primary care organisations take with such individuals may be seen as discriminatory. There is often a blanket, negative approach, so that others for whom treatment would be positive and rewarding (for both patient and professional) also find it impossible to gain access to such care or services. As one stakeholder put it, *“sometimes they’re on to a hiding to nothing, even when they’re engaging in treatment”*.

Whilst access to services, like a pharmacy, can therefore be difficult for some, others in the offender cohort can actually get healthcare access that may actually be better than the average civilian. For example, in APs the residents get access to a weekly GP visit, have their taxis paid for if they have to visit A&E, and have staff acting as advocates on their behalf in many cases. One member of staff referred to it as *“not quite gold, but silver standard service”*. There will undoubtedly be those arguing for cuts to that level of service, given budget cuts affecting the public sector – however, it is recommended that any change in service levels should consider the wider implications of removing access. For example, two of the offenders interviewed in Linden Bank remarked how they would not go to a GP if it meant travelling far from the hostel, as they felt paranoid that they would be attacked after recent local media stories relating to the threats posed by residents in the AP.

Impact of not engaging if the offender is a parent or carer

Several stakeholders emphasised the actual and perceived barriers that exist for parents or carers who are offenders, particularly if they have been in prison. In custody, they may be used to getting healthcare that is easily accessed and their lifestyle in detention frees them from some of the complications associated with looking after their own health. Once back in the community however, if they’re not used to accessing GP care, it may be a completely new experience for them to have to make more of an effort to go to a surgery - not only looking after their own health but also the added efforts associated with organising healthcare visits and associated medical treatments for their children or families.

In TWW, having most of the support services under one roof was cited as a key factor in removing perceived barriers to accessing healthcare for the women service users, having a positive knock-on effect of giving them more time to fulfil their often time-consuming roles as carers in many cases.

Seeking help

Very few of the offenders interviewed expressed the view that they had problems in accessing the care they need. In a few cases, there were issues relating to accessibility and travelling to specialist care services – for example,

not having an up to date travel plan to guide one offender from Bunbury House to specialist treatment in a Manchester hospital, via public transport.

As well as travel accessibility for a cohort often dependant on public transport, other examples of practical barriers to accessing care were given. One was the impact that changing a mobile phone number can have for people who are often transient and don't have a landline. For one offender, being told by surgery staff that they don't have the right contact number, and the perceived inconvenience and time that updating the systems caused, was cited as a barrier to making the effort to attend a GP.

Communication and aggression

Lacking basic communication skills is a regularly referred to barrier impeding how offenders access healthcare. Past conflicts witnessed by GPs involving aggressive offenders, surgery receptionists and other members of the community, were seen by many as a potential reason why some GPs turned a blind eye to the needs of offenders.

GPs interviewed accepted that problems still exist. One conceded that *"In terms of how the receptionists behave, yes, the front of house isn't right all the time. But you've got to understand that those members of staff aren't the most highly paid. In my practice there is training in conflict resolution, and we are set up to do the right thing"*. Another who worked regularly with drug addicts recalled his horror to find that one of the nurses in the local A&E made a point of leaving one heroin addict to the end of the queue in the waiting room, because she'd had a bad experience with him in the past. This was deemed not acceptable by the GP in question, who noted how aggressive the wait had made that person.

Policy links or service implications

- 3.3.3 Effective engagement between offenders and healthcare in the community is reliant on a range of success factors, including:
- knowledge and enthusiasm shown by the GP and surgery staff;
 - proper staff training and resources;
 - control of numbers of offenders accepted in the surgery;
 - the use of tailored care and treatment contracts with patients;
 - a willingness on the part of the offender to be civil.
- 3.3.4 An important, and often understandable, source of stigma and discriminatory attitudes among primary care professionals is bad experiences with a minority of offenders. And yet the numbers resorting to violence and anti-social behaviour are very small. However they are often persistent, time consuming, cause disproportionate damage to a practice's professional image and can seriously affect the care that can be properly applied to other patients. Those offenders who comply, engage with routines and process, and do well in treatment are not the ones who are remembered!

3.4 Joined-up services need joined-up systems

Key Facts:

- From prisons to custody suites to community agencies – accessing and sharing intelligence about offenders in the community appears more difficult than it should be, if requests for information for this study are anything to go by. Staffing levels and cuts in training appear to have impacted upon the speed with which agencies respond to requests, as well as (in some cases) staff not fully appreciating the importance of providing timely intelligence.
- The importance of the JSNA as the shared evidence base used to identify priorities cannot be understated, and ensuring this has a regularly updated, comprehensive overview of the health needs of offenders in the community is essential. As can be seen in Appendix A4, at present there is inconsistency in the availability of intelligence on this cohort across Cheshire, Warrington and Wirral.
- Notable practice exists locally in terms of information platforms to share intelligence – DORIC is a great example of a system that provides easy access to a wealth of information on the Cheshire and Warrington populations. However, as with any information portal, it is reliant on the quality and timeliness of updates.

3.4.1 The Appendices provide access to the data associated with this study. In gathering evidence and intelligence for this exercise, it was evident from both talking to stakeholders and personally requesting supporting data that many information systems were often limited in terms of being easily interrogated by health and CJS professionals, and that analytical staff resources were stretched in many agencies.

3.4.2 This section of the report looks at some of the process issues that get in the way of extracting and sharing relevant intelligence regarding the offender population.

What did the interviews reveal?

Joined up services need joined up systems

From prisons to custody suites to community agencies – accessing monitoring information is more difficult than it should be. For example:

- Access to updated prison prevalence statistics, to compare with those presented in the Merseyside 2012 HNA produced by Liverpool Public Health Observatory, was not possible within the time constraints, due to a lack of adequately trained SystemOne analysts in the Cheshire prisons.
- Custody suite healthcare monitoring is paper-based, and whilst an IT system is in the process of being procured, there are major barriers for managers in being able to easily gather monitoring statistics on service users (as proved the case in the 2012 custody suite HNA).

Training and sharing knowledge

As outlined in the previous paragraphs, too often a request for supporting statistics ground to a shuddering halt due to a lack of available analytical staff. Whilst some of the resourcing issues can be blamed on public sector cuts, it is important to cascade information analysis techniques across staffing levels and continue to invest time in knowledge transfer. Commissioners need to specify this requirement of services commissioned. During the course of the research it was also evident how information sharing cultures and use of statistics vary greatly across healthcare and CJS agencies. As mentioned earlier, CPT

analysis stood out as good practice in terms of how well information could be presented and shared with partners.

Policy links or service implications

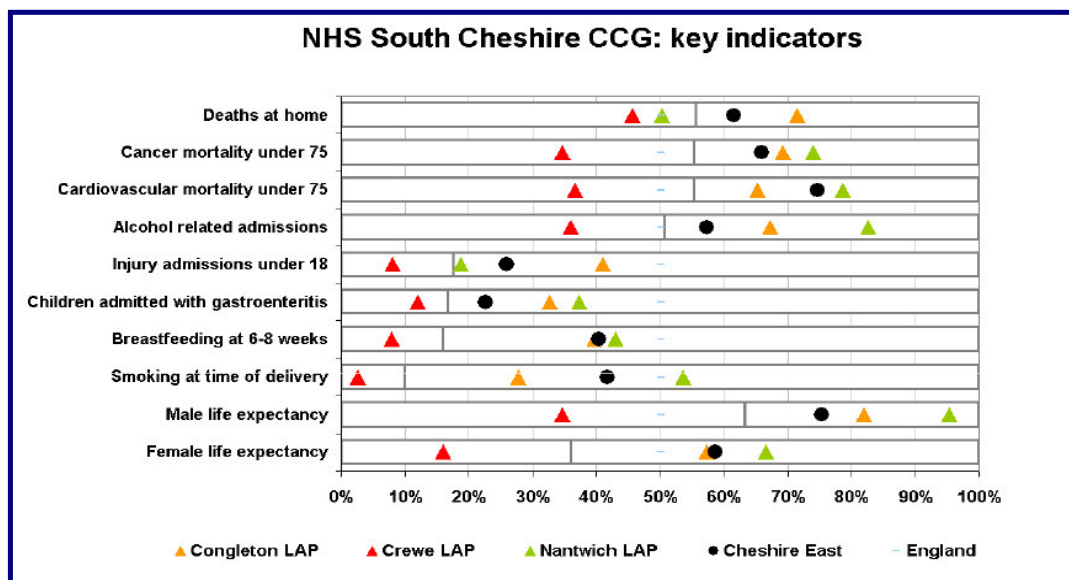
3.4.3 It is widely accepted that a shared understanding of need is key to multi-agency commissioning to improve outcomes. The importance of the JSNA as the shared evidence base used to identify priorities cannot be understated, and ensuring this has a regularly updated, comprehensive overview of the health needs of offenders in the community is essential. As can be seen in Appendix A4, at present there is inconsistency in the availability of intelligence on this cohort across Cheshire, Warrington and Wirral.

3.4.4 The boosting of a shared understanding and knowledge base is particularly relevant given this period of transition and wholesale changes impacting on offender health – including the role of PCCs, interlinked issues relating to health governance and commissioning structures. If indeed ‘PCCs may want to link the strategic priorities in the Policing and Crime Plan with both JSNAs and JHWSs in their area’,⁴⁸ then a greater two-way understanding of strategic need and service demands is needed. The PCCs locally in Cheshire and Merseyside will need to be regularly updated on the key issues affecting all elements of offender health.

3.4.5 Notable practice exists locally in terms of information platforms to share intelligence – DORIC is a great example of an initiative that provides easy access to a wealth of information on the Cheshire and Warrington populations. However, as with any system, it is reliant on the quality and timeliness of updates.

“Our aim is to provide a **‘single version of the truth’** on which local decisions can be based”.

Cheshire West and Chester Compendium of Health and Wellbeing Statistics 2012



Graphic source: Accessed via links on this DORIC web page http://www.cheshireeast.gov.uk/social_care_and_health/jsna.aspx

⁴⁸ Access here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117399/health-and-care-system.pdf
CheshireOffenderHNA_REPORT_June13_Final060613

Spotlight on:

3.5 Female offenders

Key Facts:

- Nationally and locally, there are large disparities between the healthcare needs of female offenders compared to male offenders. Local evidence shows that female offenders have significant needs to address in relation to substance misuse, relationships, emotional well-being, disability (in particular mental health), domestic violence, child care, employment and accommodation.
- The 2012/13 CPT needs assessment reveals disproportionate variations between female and male offending features or characteristics, including:
 - ~ 40% of female offenders have been victims of domestic violence (compared to 2.4% of male offenders).
 - ~ Female offenders have higher levels of needs in relation to self harm and suicide at 44.7% (26.7% of males).
 - ~ 36% of female offenders have disabilities (20% of males). Of that 36% of female offenders, 68% of that number have mental health problems (55% of male offenders)
 - ~ A greater percentage of female offenders are users of Class A, injected and addictive drugs.
- Positive actions have been taken locally to cater for these specific needs – including the SAFE requirement in Cheshire, and the Wirral ‘under one roof’ approach to service provision adopted by TWW.

3.5.1 It is well documented that there can be large disparities between the healthcare needs of female offenders compared to male offenders. For example, national statistics quoted in the 2012 HMP Styal health needs assessment reveal that:

- Around 70% of females entering custody will require a clinical detoxification compared to 50% of the males entering custody. Like men, women tend to have very complex substance misuse patterns involving a variety of substances.
- According to the Social Exclusion Unit 70% of all sentenced female women suffer from two or more mental health disorders, which is thirty five times higher than the general population. It is also of concern that women who have an increased level of substance use and a mental health disorder have an increased risk of suicide and self-harm.
- Rates of anxiety and depression were 36% for females on remand and 31% for sentenced, compared to 26% and 19% for their male counterparts.

3.5.2 Fieldwork for this needs assessment therefore included stakeholder and offender interviews at TWW, and interviews in HMPYOI Styal, together with a sample of female peer mentors.

*“I don’t like coming out on my own, but **their therapy sessions have helped. I think they’re brilliant here**”*
TWW service user

What did the interviews reveal?

3.5.3 A selection of findings relating to the needs of female offenders are:

- All of the women interviewed in TWW were complimentary about the services provided at the Wirral centre. A common thread in conversations was the ability to access numerous support programmes and service providers 'under one roof' at TWW.
- Of the seven women interviewed, it is worth noting that four highlighted mental health conditions.
- The female interviewees in TWW were not complimentary of the general healthcare experienced in HMPYOI Styal, and several highlighted the inconsistency between GPs with regard to their levels of understanding and attitudes to alcohol misuse. See Section 3.1 for more.
- Prison was perceived to have a detrimental impact on the health of female offenders with multiple needs. Interviews in TWW with those who had served short stays in prison reiterated how detention can be a backward step. One had served 6 and 10 weeks in 2010 and 2012 respectively, and explained how both stays had completely disrupted her recovery regime.
- The HMPYOI Styal discussion group highlighted the under-resourcing of services for female offenders, relating to alcohol treatment, learning disabilities and mental health.

What do supporting statistics and assessments tell us?

3.5.4 Statistics presented in CPT's extremely informative 'Equality Act 2010 - Annual Equalities Report 2012/13'⁴⁹ reveal the following about female offender needs:

- *"For the majority of female offenders, offence patterns, levels of seriousness and risk of serious harm are significantly lower and are very different to those of male offenders, as are their needs. This data is especially critical when considering the proposals made by probation and sentences made by courts. It is to be expected that there will be a significant disproportionality between the levels of males and the levels of female offenders being sentenced to custody and CPT's data annually shows that lower numbers of female offenders go into custody.*
- *Also because of the differences in the offence patterns, levels of seriousness and risk of serious harm, women are less likely than men to be proposed Supervision with an Accredited Programme, as the assessment process targets more entrenched offending behaviour and higher levels of risk, seriousness and harm.*
- *Female offenders make up only 10% of the offender population.*
- *A significantly lower proportion of women than men are consistently proposed and sentenced to custody.*
- *Significant proportions of female offenders in prison and probation settings present with similar multiple complex needs that can only be addressed through multiple interventions, many of which lie outside of the criminal justice sector.*

"I get support from St Caths for my alcohol problem - they come here every two weeks and it's been great"
TWW service user

⁴⁹ Access here: http://www.cheshireprobation.org.uk/files/publications/document_272.doc
CheshireOffenderHNA_REPORT_June13_Final060613

The SNA⁵⁰ helps to provide that context and suggests that the needs that female offenders present can prove to be a barrier to staff being able to work with them to challenge their offending behaviour. The Corston Report (p.9) highlighted in 2007 that "50% of the new receptions at Holloway (were) for breach", where women were being breached for non-compliance. The women were entering custody with relatively minor index offences such as stealing a chicken, traffic violations and for some there were concurrent minor offences in relatively short periods of time.

- There are disproportionately significant differences between the levels of mental health impairment, domestic violence, sexual abuse, drug and alcohol misuse between male and female offenders. The SNA was updated for 2012/13 and shows similar levels to those in 2011/12 (where they differ significantly this is shown in brackets).
 - 40% of female offenders have been victims of domestic violence (compared to 2.4% of male offenders).
 - 65% of female offenders have needs around relationship issues that relate to their offending behaviour (compared to 4.8% of male offenders).
 - Female offenders have higher levels of needs in relation to self harm and suicide at 44.7% (26.7% of males).
 - Female offenders continued during 2012/13 to have higher levels of health problems (compared to 38% of the males). This has risen for female offenders (from 58%) to 65%.
 - 56% of female offenders have parental responsibility (39% of males) and 64% of those have at least some needs in relation to that (52% of males).
 - 11.6% of female offenders have no fixed abode or are transient and 30% (35% in 2011/12) are in unsuitable accommodation.
 - 36% of female offenders have disabilities (20% of males). Of that 36% of female offenders, 68% have mental health problems (55% of male offenders).
 - Female offenders are disproportionately users of Class A, injected and addictive drugs.
- These statistics highlight significant differences between male and female offenders which affects CPT's approach to addressing the barriers that can get in the way of compliance and challenging offending behaviour. The evidence shows that female offenders have significant needs to address in relation to substance misuse, relationships, emotional well-being, disability (in particular mental health), domestic violence, child care, employment and accommodation. In addition, female offenders have the highest levels of financial needs around both their financial situations and their ability to manage their finances and budgeting. A possible additional context is that, compared to male offenders, a higher level of female offenders have parental responsibility. Although 62% of all offenders are unemployed, females have higher levels of need than male offenders in terms of employment history, work skills and attitudes to employment.

⁵⁰ SNA = Strategic Needs Assessment, undertaken by CPT annually
CheshireOffenderHNA_REPORT_June13_Final060613

- *A recent piece of qualitative research carried out in CPT with female offenders evidenced a high level of need in relation to depression and coping skills, and employment, amongst others. The research showed that over half of the female offenders had high levels of depression. However it did also show that all of the women said they wanted employment. Women identified significant barriers for themselves around employment skills and abilities, as well as confidence. The research highlighted specific actions that CPT is now working towards to reduce the barriers, help them into employment and crime-free lives. These include:*
 - *Helping them to access and develop a range of practical employment skills, CV, interview skills and ways to increase their employability and confidence.*
 - *For the female offenders to be seen as far as possible in a women-only environment.*
 - *Providing Volunteer Mentor support.*
 - *The evidence from the Corston Report and data and analysis from CPT's SNA and the Diversity Grid show evidence in relation to significant proportions of women offenders having significant needs around domestic and personal vulnerabilities. This has led to the development of the SAFE requirement, a bespoke package of intervention specifically designed for women offenders, which is now operating across all of the LDUs.*
 - *The SAFE Requirement forms part of the sentence for female offenders and takes a holistic view to help the women address different areas of need that have contributed to their offending behaviour. Some of the problem areas for the women can be around: violence and anger management; awareness and knowledge of drugs and alcohol; confidence and life skills; parenting skills; information advice and support in relation to employment training and education; and, improving budgeting skills.*
 - *As SAFE is designed in response to women's needs related to their offending, this means that different agencies are called on to deliver certain aspects of the order, depending on the needs that arise.*
 - *The SAFE Requirement shows that given the right levels of support within a women's environment, female offenders can be extremely responsive and custodial sentences as a result of non-compliance with community penalties has decreased”.*
- 3.5.5 Finally, the Report reveals that there has been a constant increase in the levels of both male and female offenders successfully completing Drug Treatment Requirements, during 2010/11. *“Females consistently make up a much smaller proportion (20%) of the Drug Treatment Requirements profile than male offenders. They comply at a lower level than men. Research shows that this is due to the more entrenched patterns of drug taking among the female offenders who are more likely to use Class A drugs”.*
- 3.5.6 For further statistics on female offender needs:
- See Appendix A5, which includes further Probation data supplied for this project, to inform JSNA data analysis.
 - For custody/detention information, statistics from the 2012 HMP Styal needs assessment are quoted throughout earlier thematic findings sections of this Chapter, highlighting prevalence of substance misuse and mental health problems affecting women in prison. Statistics on female offenders is also included in summaries presented earlier from the 2012 Cheshire Custody Suite HNA.

3.6 Approved Premises

Key Facts:

- 15 of the 33 interviews conducted with offenders were conducted in the two APs in Cheshire.
- Access to primary healthcare provoked the most discussion in interviews, revealing:
 - Access to GPs is considered good, by management in both APs and the majority of residents interviewed.
 - Understanding the needs of people in the criminal justice system, through past work experience, is considered a key success factor when GPs deliver a service to APs.
 - Some GPs and surgery receptionists were considered 'difficult' by Probation staff. Key workers noted how receptionists in the past had sometimes treated calls relating to offenders health with disdain and differently to a call from a non-offender.
 - GPs could make life difficult through (for example) writing a sick note without a thorough diagnostic of the offender. However, as revealed in Chapter 3.3, this can be caused by GP intimidation or lack of understanding of impact on other stakeholders.
- Where someone is diagnosed with severe and enduring mental illness (such as a psychotic condition), the assessment and referral service is generally considered good. However with regard to PD in particular, the psychiatric assessment and referral process is considered very slow and inadequate by AP staff.
- Half of the AP residents interviewed highlighted difficulties in accessing adequate accommodation. Sub-standard private rented housing or homelessness is the reality for many, and this brings with it longer term health issues. Changes to social housing in 2013 may exacerbate this.
- Welfare reform also poses a risk to some, particularly substance misusers who may be prone to 'bingeing' when receiving new lump-sum monthly benefit payments.

3.6.1 CPT funds and manages two APs – namely Bunbury House (Ellesmere Port) and Linden Bank (Sandbach). These premises are available to all Cheshire Courts and outside areas for referrals, with the overarching aims of the two APs being: *to protect the public; to prevent re-offending; to provide residents with an opportunity to address their problems in a safe, stable environment; to enable residents to face up to their offending behaviour; to complete the conditions of their order or licence; to facilitate their re-settlement into the community.*⁵¹ MPT has three APs across Merseyside.

3.6.2 15 of the 33 interviews conducted with offenders were conducted in the two APs in Cheshire. In addition, staff interviews were conducted and key workers given the opportunity to submit improvement ideas via email.

3.6.3 An overview of healthcare is provided to residents on arrival as part of their induction. The APs have affiliated local GPs, who hold clinics on site on a weekly basis. When faced with medical problems, AP staff have a range of options – using local emergency or A&E services for serious issues, or using NHS Direct and out of hours calls to local GP's where the issue is non-urgent. As mentioned in the findings that follow, the GP service in particular is considered in a favourable light by staff, and as touched upon in the section of the report looking at access to healthcare, this is one of several areas where it

⁵¹ Access here: <http://www.cheshireprobation.org.uk/our-roles/approved-premises.php>
CheshireOffenderHNA_REPORT_June13_Final060613

could be justifiably argued that AP residents have better access to healthcare than the average citizen in the community.

- 3.6.4 The remainder of this section of the report considers findings identified through engagement with residents and staff, concluding with service provision issues.

What did the interviews reveal?

GP access and 'success' factors

- 3.6.5 Access to GPs is considered good, by management in both APs and the majority of residents interviewed. A Doctor and a Community Psychiatric Nurse regularly visit both APs. In Linden Bank this service is based around a weekly visit by a GP every Monday, with appointments planned at weekends. Residents in Linden Bank were overwhelmingly positive about the service, with only a couple of offenders highlighting time limitations for appointments with the GP as a weakness.
- 3.6.6 Understanding the needs of people in the criminal justice system, through past work experience, is considered a key success factor when GPs deliver a successful service to APs. For example, one of the local GPs for Bunbury House residents has worked in prison environments, and this was flagged as an important element for why improvements had been seen in this service.
- 3.6.7 Some GPs and surgery receptionists were considered 'difficult' by Probation staff. Key workers at Bunbury House noted how receptionists in the past had sometimes treated calls relating to offenders health with "*disdain, as though these people were a nuisance*", and differently to the average civilian. GPs could make life difficult through (for example) writing a sick note without a thorough diagnostic of the offender. Improving communication and understanding between GPs, surgery receptionists and AP staff is essential to ensure offenders effectively engage with all stakeholders.

"The current GP system is great as long as the current GP is there"
AP staff

Mental health

- 3.6.8 An as-yet unpublished review of healthcare in APs by DH/NOMs, drafted in late 2012, highlights that, nationally, "*arrangements for access to mental health services are patchy and there are significant gaps in provision in over half of the APs visited*". This appears to be mirrored in Cheshire APs. Where someone is diagnosed with severe and enduring mental illness (such as a psychotic condition), the assessment and referral service is generally considered good. However with regard to PD in particular, the psychiatric assessment and referral process is considered very slow and inadequate by staff. Since the interviews with AP staff, however, CPT has secured funding for specialist PD support in Cheshire East and Cheshire West, which will hopefully cascade expertise.
- 3.6.9 This is considered an area where there is a gap, and a potential risk to resident and staff alike, considering that "*there are only two operational staff on duty each day who don't have specialist training*".
- 3.6.10 Outside of the AP environment, PD is a recurring issue mentioned in many of the stakeholder meetings, as an area of unmet need and barrier to offender engagement. PD has been mentioned by several local Probation staff as an increasingly common barrier to the successful completion of accredited programmes and community rehabilitation activities by offenders.

"I have real worries we have people coming here because they cant find suitable accommodation for people with personality disorders... people coming here who need more structured, supported accommodation"
AP staff

Wider health needs associated with accommodation

- 3.6.11 Whilst the diversity of health needs is evident, an area of commonality for approximately half the AP residents interviewed is a difficulty in accessing housing, which is a 'wider health need' that requires addressing. This relates to the next steps taken by AP residents in finding their own accommodation.

Stringent social landlord selection criteria, council waiting lists and general complexity of the application system were cited as problem areas for residents.

- 3.6.12 Where this has health implications relates to the common 'work-around' solution given by residents to the barriers they face – namely to seek private rented accommodation. The common lack of decency standards in the private rented sector, coupled with the likelihood that offenders may seek out landlords who don't request rigorous reference checks and who are frequently (by default) owners of poorer quality accommodation, presents a longer term health risk.

Health-related welfare issues

- 3.6.13 Difficulties in understanding and potentially accessing future welfare and benefits was raised as a concern by several AP residents, given changes to the welfare system in 2013 - with the notable example being the introduction of Universal Credit and payment of rent money into the accounts of housing tenants rather than landlords. Personal financial management out in the community, without the level of 'hand-holding' that residents are used to, could present several challenges - including the potential for drug/alcohol overdose (in the case of substance misusers) at times of the month when benefits are paid as a lump sum to individuals to manage, instead of funds being automatically redirected to landlords and other service providers.

What do supporting statistics and assessments tell us?

- 3.6.14 In the absence of any detailed statistics on offending and re-offending in APs, this section of the report highlights a few locally specific statistics on accommodation needs of offenders in the community, which vary across the geographical 'patch'. For example, analysis of CPT OASys assessment completions at commencement of supervision reveals:

“No fixed abode (NFA) / Transient

In 2012, 380 Cheshire offenders (16.9%) were of no fixed abode or in transient accommodation at the start of their supervision. Of these:

- o There were 88 Cheshire East offenders, representing 14% of the Cheshire East total.*
- o 121 Cheshire West offenders, representing 16% of the Cheshire West total.*
- o 92 Warrington offenders representing 18.8% of the Warrington total.*

Suitability

In 2012, 821 Cheshire offenders (representing 36.6% of the Cheshire total) had accommodation suitability needs. 20.5% had the highest level of needs. Of these:

- o 198 Cheshire East offenders representing 31.9% of the Cheshire East total had accommodation suitability needs. 17.9% had the highest level of needs.*
- o 291 Cheshire West offenders representing 39% of the Cheshire West total had accommodation suitability needs. 20% had the highest level of needs.*
- o 175 Warrington offenders representing 35.8% of the Warrington total had accommodation suitability needs. 21.5% had the highest level of needs.*

Accommodation Needs by Age/Gender/Disability/Ethnicity

Cheshire wide, 2012 showed a very similar pattern to 2011 with the 18-24 age group and male offenders having much higher proportions of accommodation permanence needs than all other groups. For ethnicity, compared to last year the trend is the same but the difference in permanence has increased. The needs of those with disabilities on the whole mirrored those of all offenders”.

- 3.6.15 A full analysis of crime related factors and need is included in Appendix A5, revealing year-on-year changes by authority area for Cheshire East, Cheshire West, Warrington and Wirral.

3.7 Military veterans

Key Facts:

- Recent national research reveals that young, male military veterans are almost four times as likely to have committed a violent offence as male civilians of the same age; however, those who have served in the military are less likely to be convicted of other types of crime.
- Astral Advisory were commissioned by Central and Eastern Cheshire PCT to deliver a veterans in custody (VIC) needs assessment – findings from a working draft are presented in this Chapter.
- Significant mental health needs were identified in Astral’s offender interviews, including:
 - 44% have issues with anger and aggression.
 - 44% experience difficulty sleeping due to mental health (including flash backs and vivid dreams).
 - 40% have general mental health issues including trauma.
 - 32% experience stress, depression or anxiety.
 - 32% have post traumatic stress disorder.

3.7.1 Research findings from King’s Centre for Military Health Research (Kings College London)⁵² released in March 2013, reveal that young, male military veterans are almost four times as likely to have committed a violent offence than men of the same age in the general population, however, those who have served in the military are less likely to be convicted of other types of crime.

3.7.2 This latest study cast further light on several of the stark findings that emerged in 2011 from the Howard League for Penal Reform final report of the independent inquiry into former armed service personnel in prison⁵³. In this study, it had been found that veterans are twice as likely to be convicted for sex offences than other people and more likely to commit violent offences. Other findings from the 2011 publication include:

- War veterans make up the largest group of people in prisons and the problem is likely to get worse after a decade of conflict;
- Most of the prisoners were older than the average criminal when they first offended – which was about 10 years after leaving the forces. This is when mental health problems are thought most likely to surface;
- The inquiry found there were about 3,000 former service personnel in jail, or 3.5% of the prison population in England and Wales.

3.7.3 To understand more about this important offender cohort, Astral Advisory were commissioned by Central and Eastern Cheshire PCT to deliver a veterans in custody needs assessment. This section of the report summarises some of the key findings that are emerging from that work, although it should be stressed that these are findings from a working draft report, that is due to be finalised in Summer 2013.

3.7.4 25 interviews were conducted with veterans in custody, of which 20 interviews were one-to-one and there was one focus group of five veterans. These interviews have taken place across HMP Altcourse (9 veterans), HMPYOI Thorn

“When it comes to the effectiveness of mentors, its amazing how there’s a quicker bonding when a peer mentor is involved – vet mentors are able to talk ‘army speak’”
Probation staff

⁵² Access here: <http://www.kcl.ac.uk/kcmhr/publications/assetfiles/iraqafghan/macmanus2013violentoffending.pdf>

⁵³ Access here: http://www.howardleague.org/military-inquiry/CheshireOffenderHNA_REPORT_June13_Final060613

Cross (5 veterans), HMP Liverpool (6 veterans) and HMP Risley (5 veterans). There were no identified veterans in HMPYOI Styal.

3.7.5 In addition, 18 Stakeholder interviews have taken place across all five prisons, CPT and prison healthcare teams.

3.7.6 To date, the main findings from the working draft report are:

- “[Prevalence of] mental health and substance misuse - particularly around post traumatic stress disorder (PTSD).
- Physical health is often better than for other prisoners, due to military experience and a clearer idea on diet and motivated to use the gym.
- Veterans in Custody Support Officers (VICSO) role is essential in engaging veterans and is more successful where the VICSO is a veteran themselves - not all veterans are being identified at admission to the prison in some circumstances (not always being asked or veterans not disclosing).
- Common feedback from the veterans has been the need to ‘soldier on’, not wanting to ask for help and the guilt they feel for being in prison. 3 veterans reported they prefer to be in prison than in the community as the regime of prison means their mental health is slightly more under control.
- Wider health issues have had an impact when they have rejoined civilian life and had difficulty in asking for help, however most would like support before release on issues such as housing, employment and counseling.
- Healthcare teams do not know when a prisoner is a veteran in custody (VIC) unless they identify themselves as one (which most don't), however this information would assist healthcare (particularly mental health teams) to look at the impact of experiences and behaviour.
- Healthcare teams may like further training on working with VICs, particularly around mental health and PTSD”.

3.7.7 Data from 25 interviews with veterans in custody includes the following health issues:

Mental health need	Number of veterans	Percentage of veterans interviewed
Issues with anger and aggression	11	44%
Difficulty sleeping due to mental health (including flash backs and vivid dreams)	11	44%
General mental health issues including trauma	10	40%
Stress, depression or anxiety	8	32%
PTSD	8	32%
Attempted suicide	3	12%
Bipolar	1	4%
Personality disorder	1	4%

Substance misuse	Number of veterans	Percentage
Alcohol misuse	10	40%
Drug misuse	7	28%

Table(s) source: Pratt, J (2013) Veterans in Custody in Cheshire & Merseyside – A Summary of Needs. To be published Summer 2013 [Astral Advisory]

3.8 Prison healthcare

Key Facts:

- The three prisons in Cheshire vary greatly in size, category and inmate characteristics – accommodating prisoners from far beyond the Cheshire/Merseyside area. This provides a challenge to local commissioners who seek consistent care pathways for locally-resident offenders.
- The thematic findings at the start of Chapter 3 focus upon four themes that emerged during the fieldwork (alcohol/drug misuse, mental health, access to care and joining up intelligence) and include a prison perspective on each.
- Interviews with prison staff revealed:
 - Transition difficulties still exist for offenders moving between community and prison settings. The piloting of a pre-release management programme is a positive step, and needs to be evaluated.
 - The need to review service provision for alcoholics, those with learning disabilities and mental health issues in HMP/YOI Styal.
- It is essential that the impetus to update prison HNAs annually is maintained, as they are an essential component of the evidence base on local offenders. Only the HMP/YOI Styal HNA has been updated since the start of 2012.

3.8.1 The three prisons in Cheshire vary greatly in size, category and inmate characteristics. The 2012 HNA produced by the North West Regional Offender Health Team for Cheshire Custody Suite healthcare commissioning in 2012, presented the following summary of key facts about the three prisons in the Cheshire Area:

Prison Name	Prison Category	Operational Capacity (ie maximum number of detainees held in the establishment)	% of Offender Population from Cheshire area	Area in Cheshire Prison occupies
HMP Risley	C	1095	22%	Warrington
HMP / YOI Styal	Female	460	7%	Styal
HMPYOI Thorn Cross	Male YOI	322	6%	Warrington
Total		1877 (max) prisoners residing in Cheshire Prisons		

Table source: Adapted from Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p6)

3.8.2 Healthcare provision in the Cheshire prisons is summarised in each of the three most recent health needs assessments produced for the three Cheshire institutions. Not having regular refreshes of these essential documents means that much of the service review information is dated unfortunately. It is hoped that funding can be found to update these, as they are an essential component of the evidence base on local offenders.

- 3.8.3 Since publication of the latest HNA documents for the prisons, Spectrum and Delphi Medical/Lifeline have been commissioned to deliver primary healthcare and substance misuse services in HMPYOI Styal, whilst CRI have provided clinical and non-clinical drug and alcohol services in HMP Risley and HMPYOI Thorn Cross from January 2013.
- 3.8.4 All prisoners are seen by a member of the healthcare team as part of their reception into prison and an assessment is undertaken of their existing health issues, including mental health and substance abuse. Any further primary care treatment / support required will be available to the prisoner for the duration of their stay in the establishments. External health provision may be sourced should the need arise.
- 3.8.5 To identify the links between healthcare needs in the community and custodial settings, interviews were conducted with the Head of Offender Healthcare at HMP Risley and HMPYOI Thorn Cross, and the Operational Services Manager at HMPYOI Styal. A discussion group with staff was also held at HMPYOI Styal, and a tour of healthcare facilities at both HMPYOI Styal and HMPYOI Thorn Cross to observe working practices.

What did the interviews reveal?

- 3.8.6 The thematic findings at the start of Chapter 3 focus upon four themes that emerged during the fieldwork (alcohol/drug misuse, mental health, access to care and joining up intelligence) and include a prison perspective on each, where relevant, together with any supporting evidence from prison HNAs. Rather than repeat the findings from earlier, this section of the report provide a broad overview on three issues that emerged during prison interviews – with readers advised to explore the thematic sections of Chapter 3.

“GPs often look down on offenders. But it’s really important that people leaving here understand the appropriate way to access health services – before a crisis. The new contract here will include ‘through the gate’ work, which coaches offenders on how to access resources when out”
HMP Styal staff

Overcoming transition difficulties

Whilst transition between custodial settings and community has improved considerably for many offenders over the years, there are still process failure points. It is encouraging that healthcare managers in HMP Risley and HMPYOI Thorn Cross realise that more could be done to improve the discharge of prisoners, piloting pre-release management programmes to support the transition, appreciating the flaws in the standard two side discharge summary reports and expectations of prisoner self-referral to GPs once out in the community. However, consistency in approach is needed across the prison estate, given the amount of transfers and nationwide spread of locally-based offenders.

The need to improve transition and continuity of care was raised several times by a range of stakeholders. For example, drug treatment staff in Cheshire West noted how mental health medication was an area that often let offenders down, with an assessment in prison triggering a prescription however the person’s GP in the community then stopping that medication, as they will not continue without re-assessment. AP staff also highlighted the variation in medication prescriptions between custody and community, whilst many offenders flagged the transition weeks as being particularly risky for them in terms of relapsing into previous behaviours and routines.

The ‘invisible’ alcoholics, learning disabilities and mental health – three areas to focus resource in HMPYOI Styal?

The six staff involved in the HMPYOI Styal discussion group were asked what three areas they would chose as areas for improvement – and the three were alcohol services, better mental health provision and more resources to cope

with learning difficulties. This is reviewed in more detail in the thematic findings presented in sections 3.1 to 3.4 of this report.

Differing perspectives on quality of prison care

The stakeholders interviewed were, on the whole, positive about offenders' access to healthcare and the quality of services in prisons – citing:

- the 24 hour access to care available, which is considered a '*positive inequality*' when compared to the access barriers faced by civilians.
- Prisons as places where offenders were being looked after one-to-one, with individuals using the discipline of the regimes to focus on their healthcare after years of neglect.

Conversely, the vast majority of offenders in the community who had been in custody were critical of prison healthcare, with common areas of concern being: conflicts with GPs over their demands for medication; waiting times in certain prisons for dentistry and optician services; problems with alcohol withdrawal. The one area that offenders were almost completely complimentary about was the quality of dentistry available.

What do supporting statistics and assessments tell us?

- 3.8.7 The three most recent prison HNAs reveal emerging issues and recommendations to commissioners, whilst each of the first three thematic sections at the start of Chapter 3 present key findings relating to alcohol misuse, drug misuse and mental health, that draw on evidence collected for this study from prison stakeholders.
- 3.8.8 Commissioners are therefore advised to access the three prison HNAs to understand some of the interlinked health needs that impact on community provision as offenders are released.

3.9 Custody suites

Key Facts:

- Healthcare in Wirral and Cheshire Custody Suites is changing – as both Cheshire Constabulary and Merseyside Police embrace the ‘Early Adopter’ model of healthcare provision.
- Interviews with staff in Cheshire considered the impact of a new health service contract starting in May 2013, and highlighted:
 - Potential for more proactive health promotion.
 - The need for an effective IT solution.
 - Better engagement with referral agencies and health promotion services.
 - Changing demographic of service user impacting on service provision.
- Being able to measure impact and outcomes post-May 2013, rather than process such as number of referrals, calls for an appropriate evaluation framework to be devised, requiring:
 - effective monitoring and information systems to be in place.
 - outcome measurement taking in the widest cohort possible – ideally extending, for example, health screening for all detainees and not just those seen by the healthcare provider for medical treatment. Those who are voluntary attendees could easily be an ‘invisible’ cohort when evaluating healthcare in custody.

3.9.1 Cheshire Constabulary is part of the national ‘Early Adopter’ model of healthcare provision in custody suites being transferred to the DH from the Home Office. Merseyside Police are in the second wave⁵⁴ of Early Adopters, launched in March 2012.

3.9.2 The organisational benefits to the police of becoming an ‘Early Adopter’ include:

- the prospect of a reduction in re-offending based upon better engagement with health services particularly around drug, alcohol and mental health provision.
- Improved engagement with health colleagues to signpost and manage the healthcare of offenders upon their return to the community, to reduce their re-offending.

3.9.3 For the NHS, anticipated benefits include earlier identification and management of clinical needs for disengaged groups, who often fail to register with healthcare services in the community. It is hoped that this will be another vital step in reducing the likelihood of such groups presenting to NHS services at a point of crisis, ultimately improving public health outcomes.

3.9.4 In Cheshire, there are three purpose-built custody suites, which are located in Runcorn, Middlewich, and Blacon, Chester. In Wirral, there is a custody suite in Birkenhead. The Custody Chief Inspector is responsible for the management of the custody centres and all of the staff within the unit. He is the strategic lead for contract management in respect of the provision of outsourced medical services and interpreters for the force.

3.9.5 The obvious connection between the objectives of the early adopter model and offender needs in the community meant that custody suite stakeholders were included in the fieldwork. The interviews were timely, as a new contract for healthcare in Cheshire had just been awarded, with Tascor having been

⁵⁴ Access here: <http://www.networks.nhs.uk/nhs-networks/health-and-criminal-justice-liaison-and-diversion/documents/Wave%202%20Launch%20Event%20slides%20-%20FINAL.ppt#457,14,Building on what works: Multi Agency Working>
CheshireOffenderHNA_REPORT_June13_Final060613

commissioned to deliver a revamped service from May 2013. In Wirral, Madacs provide health services and ARCH Initiatives staff provide advice and help for those arrested for drug or alcohol related offences. The time limitations associated with this research meant that interviews were focused on Cheshire.

- 3.9.6 Interviews were conducted in Runcorn and Middlewich custody suites, with three 'strategic' members of staff – the Tascor clinical lead, a nurse who covered all four suites and a business manager from Tascor. In addition, the Custody Chief Inspector was interviewed at Cheshire Constabulary Headquarters.

What did the interviews reveal?

Potential for more proactive health promotion, post-May 2013

The new contract for healthcare that Tascor are to deliver from May appears quite a shift in care provision. Staff note several positive changes:

- Traditionally seen as detainees, the service user will be dealt with as a patient in a nurse-led service.
- Health promotion will take up a much greater proportion of time for the nurses and healthcare staff in the custody suites. Locally tailored leaflets are available for a whole range of services (from smoking cessation to sexual health) and the important change to note is that nurses will proactively seek time with the service users to promote changes to lifestyle and signposting to services.

“Why do we have so many services in the community? We seem to just refer, to refer, to refer.... Instead we should have a ‘one-stop-custody-shop’”
Custody suite staff

The need for an effective IT solution

At the time of interviewing, a flaw in how healthcare operated in the suites revolved around the paper-based system in place. A new IT system was 'imminent' which was seen as crucial in ensuring the healthcare staff could effectively deal with service users. Staff commented on how many of the service users were seen repeatedly, but staff were unable to track easily how their healthcare pathway had evolved over the years due to the records not being kept on computers. This has obvious spin-off repercussions on the ability to provide a 'joined up' approach with other service providers.

Better engagement with health promotion services

Whilst one of the key objectives behind 'early adopter' status is better engagement with health services, particularly around drug, alcohol and mental health provision, staff were keen to point out that this created new challenges, including:

- A more expansive outcome focus to the contract performance framework meant that agencies being referred on to would be judged on their effectiveness. The new IT system will hopefully enable engagement by service users with referral agencies easier to monitor and assess.
- The present abundance of form filling was seen as a huge inefficiency, taking up excessive staff time. One staff member commented on the seemingly excessive number of agencies and services that appear to over-complicate referral and signposting to support.

Changing demographic impacting on service provision

The demographic characteristics of Cheshire Custody Suite service users has changed in the last three years, and numbers attending has fallen quite dramatically - linked to changes in police practice, particularly relating to the use

of 'no further action' procedures that meant that minor offences did not necessarily require immediate attendance at the suites. On the Cheshire Constabulary website, service use figures are quoted – noting that 'approximately 30,000 detainees per year in total are detained at the custody suites'. The recent HNA conducted in 2012 quote a figure of just under 25,000. This has several implications:

- The falling numbers of attendees has a potential positive impact on healthcare provision, as during quieter periods, nurses and healthcare staff will be able to undertake more health promotion activities than in previous years.
- The new, core demographic attending is seen by staff as being the particularly vulnerable – who are on the whole considered 'treatment naïve' in many cases. This raises new challenges for the service provider, given that the success of the new contract will not be about numbers of referrals and outputs, but outcomes relating to success in impacting on recovery.

What do supporting statistics and assessments tell us?

3.9.7 The text and tables that follow are taken from the latest HNA document, produced for Cheshire Custody Suite healthcare commissioning in 2012 by the North West Regional Offender Health Team.

- *"The three custody suites have a throughput of 24,940 offenders annually.*

<i>Total No. through Cheshire Police Custody</i>												
<i>Nov</i>	<i>Dec</i>	<i>Jan</i>	<i>Feb</i>	<i>Mar</i>	<i>Apr</i>	<i>May</i>	<i>Jun</i>	<i>Jul</i>	<i>Aug</i>	<i>Sep</i>	<i>Oct</i>	<i>Total</i>
2230	2035	2263	2055	2113	2136	2077	2063	2054	1972	1895	2047	24,940

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p6). Data received from Cheshire Police Jan 2012. Table data relates to period November 2010 to October 2011.

- *Some of these offenders require medical treatment when in custody, a breakdown of the volume of calls to Reliance⁵⁵ Medical Services for the period May 2011 - October 2011 is below.*

<i>Total No. of Calls to Reliance Medical Services for health input</i>			
	<i>Volume of calls</i>	<i>No of detainees in custody</i>	<i>% of detainees requiring clinical input</i>
May-11	847	2077	41%
Jun-11	871	2063	42%
Jul-11	734	2054	36%
Aug-11	890	1972	45%
Sep-11	745	1895	39%
Oct 11	803	2047	39%
Total	4,890	12,108	40.38

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p6)

Smoking

- *The custody data collected shows that the number of detained persons who smoke is largely not known in the Blacon and Middlewich custody suites, however Runcorn shows the higher number of detained persons who were*

⁵⁵ Reliance was re-branded Tascor in January 2013.
CheshireOffenderHNA_REPORT_June13_Final060613

shown to have cigarettes within their property where it has been assumed they therefore smoke. For this reason, one of the key recommendations will be around more informed data collection when detainees enter custody. The breakdown of this data is shown below;

Custody Suite	Number of persons detained and seen by Reliance Medical Services in the period 1 st – 31 st October 2011 who smoke based on a 10% sample of records		
	Smoker	Non-Smoker	Not Known
Blacon	9	2	13
Middlewich	10	4	12
Runcorn	17	4	5
Total	36	10	30

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p15)

Substance Misuse / Alcohol Issues

- The data collected in October 2011 shows that it is largely not known if detained persons have issues with drugs, although it is shown that Heroin and Cannabis use is high for those detainees who admit to drug use. Blacon Custody Suite has the highest number of Heroin users for the Cheshire area, with Runcorn worse affected for Cannabis and Cocaine use.
- Based on the records reviewed in police custody, it is shown that those detained persons who present at custody who admit to drug use do not appear to be in contact with drug services to obtain support for their problem, however this could be the Provider not collating this information. The breakdown of drug use data is below;

Custody Suite	No of persons detained and seen by Reliance Medical Services in the period 1 st – 31 st October 2011 with Drug issues based on a 10% sample of records						
	Heroin	Cannabis	Cocaine	Other	None	Not Known	In contact with Drug Services
Blacon	3	3	1	3	5	9	0
Middlewich	1	2	0	0	6	17	0
Runcorn	1	3	3	0	13	6	0
Total	5	8	4	3	24	32	0

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p16)

- Based on the sample of records reviewed, 24% of detainees seen by Reliance Medical Services for medical treatment in the month of October 2011 were under the influence of alcohol on arrest, which may have contributed to their offence. However, it is not known for 47% of those seen by Reliance Medical Services if an alcohol problem existed, with only 21% admitting to having a problem. Again, the data collected largely shows that it is not known if detainees are in contact with services for their alcohol issues.
- Middlewich and Runcorn Custody Suites had the higher number of detainees who were under the influence of alcohol on arrest. The breakdown of alcohol use data is below;

<i>Custody Suite</i>	<i>No of persons detained and seen by Reliance Medical Services in the period 1st – 31st October 2011 with Alcohol issues based on a 10% sample of records</i>					
	Alcoholic	Under the Influence of Alcohol on Arrest	Alcohol Use	None	Not Known	In contact with Alcohol Services
<i>Blacon</i>	6	0	2	1	15	0
<i>Middlewich</i>	5	7	0	1	13	0
<i>Runcorn</i>	5	11	1	1	8	0
Total	16	18	3	3	36	0

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p16)

- *It is understood from Cheshire Drug and Alcohol Team that Blacon, Middlewich and Runcorn Custody Suites operate a drug arrest referral service, and Drug Intervention Programme (DiP) workers regularly visit the custody facilities to speak with detainees who may need support for their drug issues. The aim of the service is to direct detainees into treatment where the need arises, or to work with them to reduce their offending. They are commissioned with a KPI to achieve 95% of clients on the caseload to be referred into structured treatment. In Quarter 1 and Quarter 2 of 2011 they have achieved 100% and 97% respectively. The DIP will also case manage appropriate PPO's or repeat offenders and give brief interventions to alcohol clients who are subject to a conditional caution.*
- *The area of Cheshire has had alcohol arrest referral schemes running in the custody as pilots, but these have stalled due to funding. The local PCT's commission alcohol services and have moved their focus more to the A & E departments to meet the performance target to reduce hospital admissions.*
- *Based on the data shown above for drugs and alcohol, one of the key recommendations to be made will be to ensure referrals are made to services where this is warranted with more partnership working to be encouraged between all agencies.*

Mental Health Issues

- *From the records reviewed, the number of detainees where it is not known if there are any mental health issues is high. However, where mental health problems have been identified the number of detainees who have a history of or currently suffer from depression is high, particularly in Middlewich and Runcorn custody areas. However, it should be noted that 47% of those who stated depression when asked about mental health issues also informed of a history of self harm. With 879 and 774 hospital stays for self harm per 100,000 population, in Cheshire East and Cheshire West & Chester respectively these are problematic areas for this issue as they are significantly higher than the national averages.*
- *Once again, the number of detainees who are in contact with mental health services for an identified problem is low at just 12%. The breakdown of mental health issues is below;*

<i>Custody Suite</i>	<i>No of persons detained and seen by Reliance Medical Services in the period 1st – 31st October 2011 with Mental Health issues based on a 10% sample of records</i>					
	Depression	Anxiety	Self Harm	Other (ie Psychosis, Schizophrenia)	Not Known	In contact with Mental Health Services
<i>Blacon</i>	8	2	3	3	8	4
<i>Middlewich</i>	12	2	0	1	11	1
<i>Runcorn</i>	14	1	3	1	7	1
Total	34	5	6	5	26	6

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p17)

- Two of the mental health providers, Cheshire & Wirral Partnership NHS Foundation Trust and 5 Boroughs Partnership NHS Foundation Trust, have provided data and information on the number of referrals they received for mental health in the same period:

<i>NHS Foundation Trust</i>	<i>No of referrals for the period 1st – 30th September 2011</i>
<i>Cheshire Wirral Partnership</i>	7
<i>5 Boroughs Partnership</i>	4
Total	11

Table source: Adapted from Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p17)

Health Interventions

- The custody suites in Cheshire utilise the services of Reliance Medical Services when medical treatment is required for detainees. From the data collected 37% of the reasons for a Reliance Medical Services call out was to ascertain if a detainee was fit to be detained, closely followed by 30% of 'Other' callouts which may have involved dispensing medication, pain relief or referring to A&E those detainees complaining of chest pain or head injury".

<i>Custody Suite</i>	<i>Breakdown of Reason Reliance Medical Services called out for detainees in the period 1st – 31st October 2011 based on a 10% sample of records</i>				
	Minor Injuries	Drug / Alcohol Withdrawal	Mental Health	Fitness to Detain	Other
<i>Blacon</i>	6	2	2	4	10
<i>Middlewich</i>	6	3	0	14	3
<i>Runcorn</i>	4	1	1	10	10
Total	16	6	3	28	23

Table source: Watkin, Ellis & Wilson (2012) 'Cheshire Police Force Offender Health Needs Assessment – Police Custody 2012' (p18)

CHAPTER 4. RECOMMENDATIONS

R1: Critically assess the impact of alcohol misuse services

- Within local JSNA evidence reviews, specific recommendations for commissioners relate to offender health and alcohol misuse – for example, in Cheshire West one JSNA recommendation states that *“the high level of need in relation to alcohol amongst offenders requires a review of the level and impact of services for this specific client group”*.
- Local evidence in the JSNAs should be actively publicised to commissioners, to support evaluation of ‘what works’ and identify patterns unique to their locality, such as the binge drinking needs associated with Warrington offenders identified in the 2012 CPT strategic needs data. Impact assessments should be commissioned where there are gaps in local evidence of service effectiveness.

R2: Map the gaps in effective drug recovery service provision

- As with the needs of offenders with alcohol misuse problems, it is important to join up actions across the locality. Within local JSNA evidence reviews, specific local recommendations for commissioners relate to offender health and drug misuse - including for Cheshire West to *‘conduct a mapping exercise to establish gaps in health provision for offenders’* and *‘Develop an evidence based targeted health offender strategy’*.
- It is important to evaluate the effectiveness of current drug and alcohol interventions in supporting recovery, reducing drug misuse and impacting on re-offending across Cheshire and Merseyside, and communicate lessons learnt to commissioners in the relevant CJS and health agencies.

R3: Share more notable practice on ‘what works’ for offenders with mental health problems/diagnosis and learning disabilities, and keep targeting PD

- It is vital for co-commissioners to share notable practice on ‘what works’ in the field of mental health. For example, New Directions in Warrington provides an early intervention service, for individuals with low-level problems who are at risk, but would not normally be helped until their condition had deteriorated much further. Significantly more than 60% of referrals have an offender history. The scheme has had a substantial impact on those it has worked with, achieving:
 - A 78% drop in reported crime compared to the pre-intervention rate;
 - A 71% fall in ‘Vulnerable Adult’ reports – after an initial fall of 54%;
 - A 30% reduction in anti-social behaviour in the first year of operation.
- People with learning disabilities account for approximately 8% of people brought into custody and often proceed through the CJS without being fully aware of the process or their rights. Those with learning disabilities who engage in offending behaviour often have complex needs and are often subject to exclusion from both mainstream and specialist services. Research shows that 60% of younger offenders (14-21 year-olds) have learning difficulties⁵⁶. The HMPYOI Styal discussion group highlighted the under-resourcing of services for female offenders with learning disabilities as an area of concern. As a minimum improvement action, it is imperative that staff working with offenders are empowered to support and inform people with learning disabilities about the consequences of reoffending and how to improve their health. Notable practice

⁵⁶ Access here: <http://www.sentencetrouble.info/>
CheshireOffenderHNA_REPORT_June13_Final060613

exists across Cheshire and Merseyside – for example, a staff education programme in Wirral was provided to the police custody suite staff by health service colleagues, developing leaflets and training on understanding the needs of people with learning disabilities.

- This study highlights PD as a priority concern that needs far greater resource. Stakeholders report that CPT recently won grant funding with partners in Cheshire East and Cheshire West to target this specific area of need, which is a positive development. Yet it is apparent that more PD service funding, commissioning and provision is needed.

R4: *Facilitate greater access to healthcare in the community through better stakeholder communication*

- Effective engagement between offenders and healthcare in the community is reliant on a range of success factors, including:
 - knowledge and enthusiasm shown by the GP and surgery staff;
 - proper staff training and resources;
 - control of numbers of offenders accepted in the surgery;
 - the use of tailored care and treatment contracts with patients;
 - a willingness on the part of the offender to be civil.
- Improving communication and understanding between GPs, surgery receptionists and other key stakeholders (for example, Probation staff) is essential to ensure offenders effectively engage with support structures.

R5: *Build on community support structures to help reduce female re-offending and improve women's health*

- Provision of the SAFE requirement for women offenders across all Cheshire LDUs and the launch of a Women Offenders' Strategy in summer 2012 illustrate a strong commitment from CPT towards meeting the needs of female offenders, to impact upon reoffending and wellbeing. It is vital that those involved with sentencing understand fully the impact of the penalties and measures they can administer as alternatives to custody, and apply them proportionately. Whether it is conditional cautioning, restorative justice arrangements, fines, community payback with childcare provision, women-only services for addicts, community orders with mental health requirements, flexible responses to technical breach of license – all have their part to play in reducing reoffending.
- Provision for review of sentencing outcomes and the opportunity to visit women's centres (such as TWW) would enable magistrates to make their own assessment of effectiveness. Outcomes data from centres such as TWW should be accessible to co-commissioners. The distinction in needs affecting female offenders is stressed in the NOMS Commissioning Intentions 2013-14 document – *'Commissioned and co-commissioned interventions and services also need to be sensitive to the contextual issues that impact upon women's ability to engage. These issues often include caring responsibilities, lack of transport (in the community) and higher rates of mental illness. Where possible, services should be delivered in women only groups'*.⁵⁷

R6: *Gather more robust health outcome data for APs*

- 'Without accommodation, nothing works' was a frequently heard retort when stakeholders were asked to explain how their service impacted upon reoffending

⁵⁷ Access here: <http://www.justice.gov.uk/downloads/about/noms/commissioning-intentions-2013-14-oct12.pdf>
CheshireOffenderHNA_REPORT_June13_Final060613 Page 73 of 82

and the behaviour of offenders. In Cheshire, the two APs provide a highly-valued regional resource, which contribute an essential, stabilising element in many offenders integration back into the community. Residents were overwhelmingly positive about the healthcare service they experience in the hostels. One of the gaps in this study, however, is the inclusion of outcome statistics that show before and after evidence of how a resident's stay has impacted on the offenders health. In particular further evidence is needed on whether access to mental health services has improved and specifically if the gaps identified in PD provision have been filled.

R7: *Plan ahead to cater for the needs of military veteran offenders*

- The recent research findings from King's Centre for Military Health Research into offending by military veterans (quoted in Chapter 3.7 of this report) created a wealth of media headlines that focused on the disproportionate amount of violent offences committed by young male veterans compared to men of the same age in the general population. Less publicised was the finding that violent offending was strongly associated with post-deployment alcohol misuse and post traumatic stress – something well known through anecdotal evidence, but given more statistical significance in this latest study.
- With large numbers of military personnel due to be made redundant in summer 2013⁵⁸, and a large proportion returning to the North West, the health needs of veterans, a small percentage of whom are offenders, is an emerging issue that will have implications on both health and CJS organisations. How the needs of this vulnerable group will be integrated within existing service commissioning arrangements needs to be clearly articulated.

R8: *Regularly assess health needs in the Cheshire prisons*

- Healthcare provision and offender health needs in the three Cheshire prisons is assessed through detailed health needs assessments. The last HNAs for HMP Risley and HMPYOI Thorn Cross were published in January 2011 and the refreshes of these are due. It is essential that funding is found to update these, as they are an essential component of the evidence base on local offenders - all adult offenders will have spent at least some time in one or more detention or custody facilities (in custody suites, court or prison) and that care will to some degree impact on the offender, families and wider community.
- As the DH publication '*Public health services for people in prison or other places of detention, including those held in the Young People's Secure Estate*' explains, "*most of those who enter prison or other accommodation of prescribed description spend most of their lives in the community, so any public health interventions and investments whilst in custody will have positive 'ripple' effects on their families and wider social contacts*".

R9: *Develop an appropriate evaluation framework to measure the full impact of custody suite healthcare provision on offender health outcomes and recidivism.*

- As with 'early adopters' in any walk of life, those trialing new ways of working or technologies provide vital learning points that inform enhancements to future rollouts of programmes or technologies. The same is true of the Early Adopter model of healthcare in custody suites. The commissioning of the new Tascor healthcare contract in Cheshire Custody Suites from May 2013 seeks to stretch

⁵⁸ Access here: <http://www.guardian.co.uk/uk/2013/jan/22/mod-5300-army-job-cuts>
CheshireOffenderHNA_REPORT_June13_Final060613

further the benefits of proactive health promotion and healthcare - to impact upon reoffending, improve engagement with offenders and reduce pressures on NHS services (like A&E) that are often the first point of contact for offenders in the community, usually at times of crisis. Being able to measure impact and outcomes, rather than process such as number of referrals, requires an appropriate evaluation framework to be devised, and this in turn requires effective monitoring and information systems to be in place.

- It is important that any outcome measurement takes in the widest cohort possible – ideally extending, for example, health screening for all detainees and not just those seen by the healthcare provider for medical treatment. Those who are voluntary attendees could easily be an 'invisible' cohort when evaluating healthcare in custody, so it is important to create innovative monitoring processes in 2013 to work in tandem with those developed by Tascor in Cheshire.

R10: Roll out more joined up approaches to cater for complex needs

- Within the CJS and health arenas, it is not uncommon for individual agencies to generally focus on improving outcomes for the neediest within their service (for example the most mentally ill or the most prolific drug users) but often miss those who have multiple needs. Thus, people may not meet the threshold of any given agency to trigger the most comprehensive intervention, despite the scale of their problems or the harms caused to the communities in which they live.
- Participants from a range of agencies cited the problems they experience effectively managing offenders and their healthcare needs when, in particular, offenders present with a mix of PD and other interconnected drug misuse characteristics. DIP shows how multi agency working is key to tackling health and crime reduction outcomes. The same model should apply for wider health needs. Commissioners need to build on notable practice, such as IOM that has delivered on reoffending outcomes so effectively in Warrington and parts of Merseyside. Post April-2013, new structures for sharing best practice, between agencies and across geographic boundaries, need to be clearly defined for all Cheshire strategic partners, so as to underpin the most comprehensive service provision for those with complex needs.

R11: Seek new opportunities for joined up commissioning.

- If commissioning strategies are not integrated, there is a potential gap in provision for the commissioning of services for people experiencing dual diagnosis and complex needs. Identifying common priorities and synergies within the various health, CJS and community safety strategies (including the PCC commissioning strategies for Cheshire⁵⁹ and Merseyside⁶⁰) is an obvious first step early in the new financial year.
- It is important to commission recovery orientated care pathways in tandem and across boundaries, to ensure efficient use of resources but most importantly maximise the benefits of continuity of care for the service user.

R12: Improve continuity of care for those discharged from prison

- Evaluate the pilot programme in HMP Risley regarding the assignment of a pre-release manager, who engages with the offender prior to release and physically

⁵⁹ Access here: <http://www.cheshire-pcc.gov.uk/Document-Library/Policies/Commissioning-Strategy.pdf>

⁶⁰ Access here: <http://www.merseysidepcc.info/Policy/Commissioning.aspx>

supports them to register with a GP and other healthcare processes, together with the HMPYOI Styal application of an outcome based payment model for through the gate continuity of care and handover.

- Consider the merits of rolling out across the Cheshire prisons the HMP Liverpool community prison 'Offender Passport', aimed primarily at addressing the health needs of offenders serving sentences of less than 12 months who do not have support from Probation when they are released. This involves the Community Prison Officers collecting information on a range of health needs (from health issues which are more prevalent among prisoners including mental health problems and alcohol and drug issues, to wider health needs which have been shown to have a great impact on offender health, and to impact on re-offending, including accommodation, employment/training needs, relationship status and financial situation) and working together to address these needs. On release, the offender is then offered a referral to a mentoring project.

R13: Accurately reflect offender needs in JSNA refreshes

- In September 2012 the Government completed a public consultation on draft guidance on JSNAs and JHWSs⁶¹. Several consultees raised concerns that the draft guidance did not discuss directly how JSNAs and JHWSs would engage with and support marginalised and excluded groups, such as offenders in the community. Critics argue that there is a lack of reference in the draft guidance to the 'deep' inequalities experienced by the most excluded and marginalised. A review of the present JSNA's (presented in Appendix A4) reveals an inconsistent and patchy evidence base being used, that rarely provides the detail that service commissioners would require.
- More than ever, therefore, the four respective JSNAs in Cheshire East, Cheshire West, Warrington and Wirral need to have access to consistent, comprehensive and regular evidence on offender health needs. Notable practice exists within Cheshire – for example the level of depth that CPT commit to partnership reports, including an array of statistics on offenders' dynamic risk factors. Geographically, Cheshire and Merseyside commissioners are fortunate to have specialist academic expertise so close to hand, notably in the form of Liverpool Public Health Observatory (University of Liverpool), which should be drawn upon to make sure evidence is refreshed on an annual basis. This type of research could benefit considerably from:
 - A quantitative survey being conducted with offenders in the community, to add to primarily qualitative findings presented in this study.
 - Annual refreshments to the prison and custody suite HNA documents.

R14: Promote evidence and share understanding

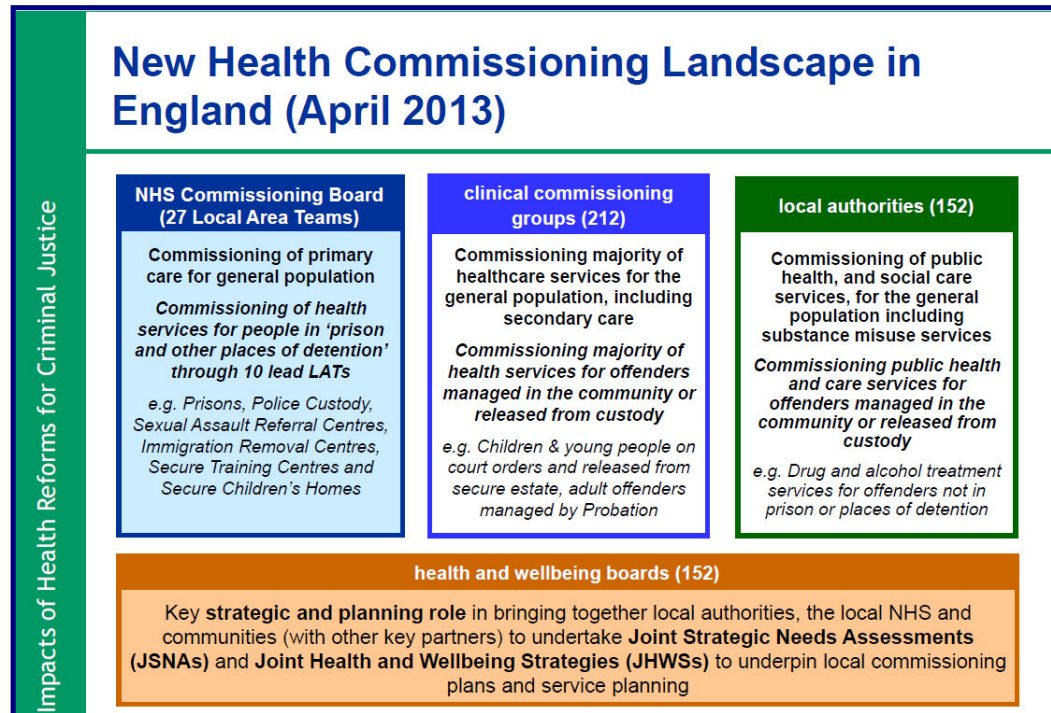
- Active awareness raising with commissioners and decision makers in the range of governance bodies who will influence offender healthcare provision (CCGS, HWBs, PCCs) is required in 2013, to map out their level of understanding and establish:
 - Whether local commissioning plans explicitly recognise the service needs of offenders and ex-offenders, including health and re-offending prevention services?
 - Will offenders be consistently supported to maintain continuity of health and social care from prison to community, across the patch?

"I am committed to supporting and encouraging effective multi agency work to target and case manage offenders who are problematic due to substance misuse or other crime related factors....I will seek to bring together partners from the Borough Councils, Drug Rehabilitation, Probation, Housing Officers, the Courts, mental health organisations, GPs and the police to develop tailored solutions for those individuals"

John Dwyer,
PCC for
Cheshire (quote
in the 2013-16
draft PCC Plan)

⁶¹ Access here: <https://www.wp.dh.gov.uk/publications/files/2012/07/Joint-Strategic-Needs-Assessment-and-Joint-Health-and-Wellbeing-Strategy-draft-guidance-a-consultation.pdf>
CheshireOffenderHNA_REPORT_June13_Final060613

- Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the HWB?
- As the present changes to the co-commissioning environment bed in during 2013, it is vital that decision makers have a rapid, full understanding of the healthcare needs of offenders. For example, when offenders leave prison and are 'repatriated' back to their host Local Authorities, the responsible hosts and commissioners need to have a full understanding of the needs of this population to effectively deal with them. Being able to commission to maximise effectiveness and efficiencies will require agencies sharing an awareness and acceptance of the benefits of integrated planning and delivery across both health and CJS agendas.



Graphic source: Marshall, S (2012) Presentation slides: 'The Impacts of Health Reforms for Commissioning of Services for People in Contact with the Criminal Justice System (in England)'

R15: Strengthen the existing evidence base

- Because the scope of this HNA was broad (covering large parts of Cheshire together with Wirral in Merseyside), and time limited to four months, the number of people interviewed per authority area was relatively low and hence the number of sub-regional recommendations specific to each JSNA is limited.
- Further work is needed to gel together the findings from the various needs assessments that are ongoing locally, whilst gaps could be filled in the coverage of this reporting through:
 - Gathering more up-to-date statistics from treatment service providers and other agencies, on prevalence rate changes specific to the offender population;
 - Interviewing prisoners who are about to return to the community, prisoners recently released, and custody suite visitors - to better identify issues relating to transition between detention and community.

R16: Monitor wider health needs associated with welfare reform

- The wholesale changes being implemented in 2013 to the welfare system, including the introduction of Universal Credit and housing benefit reforms, will transform the way benefits and other income support is administered and radically alter the social housing sector. There are a number of areas that decision makers need to monitor closely, with regard to the wider determinants of health:
 - Stakeholders pinpoint the lump sum payment of housing benefit to the tenant rather than landlord as a potential trigger for bingeing and potential drug/alcohol overdose (in the case of substance misusers) at times of the month when benefits are paid. Given the links identified in earlier Chapters between substance misuse and offenders reoffending, this should be monitored closely.
 - The potential for a reduction in social housing options available to vulnerable groups is a concern, reflecting the likelihood of RPs struggling to maintain stock levels particularly in areas where rent defaults are common. The spinoff effects of this were identified in interviews with AP residents. For many, low quality private rented accommodation is the only option. The common lack of decency standards in the private rented sector, coupled with the likelihood that offenders may seek out landlords who don't request rigorous reference checks and who are frequently (by default) owners of poorer quality accommodation, presents a longer term health risk.
 - Budget management issues, associated with the Universal Credit lump sum payments, not only cause massive direct financial pressures on service providers and recipients of benefits. Some stakeholders query whether there will be indirect cutbacks to, for example, the quality of food bought for families, money spent on prescriptions, and heating bills. There are a whole range of predicted spinoffs and interlinked themes – including landlords not getting rent directly creating new problems of evictions, homelessness and possibly relationship breakdown. The indirect measures of 'stress' on determinants of health need innovative monitoring and tracking to be put in place within JSNAs.

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Note: NHS Commissioning Board (NHSCB) was renamed NHS England on 26th March 2013.

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
APs	Approved Premises
CARATs	Counselling, Assessment, Referral, Advice and Throughcare service
CCG	Clinical Commissioning Group
CJS	Criminal Justice System
CPT	Cheshire Probation Trust
DH	Department of Health
GP	General Practitioner
HMP	Her Majesty's Prison
HNA	Health Needs Assessment
HWB	Health and Wellbeing Board
IDTS	Integrated Drug Treatment System
IOM	Integrated Offender Management
JHWS	Joint Health & Wellbeing Strategies
JSNA	Joint Strategic Needs Assessment
LDU	Local Delivery Units
MPT	Merseyside Probation Trust
NDTMS	National Drug Treatment Monitoring Systems
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NTA	National Treatment Agency for Substance Misuse
OASys	Offender Assessment System
ONS	Office for National Statistics
PCC	Police and Crime Commissioner
PD	Personality Disorder
PTSD	Post Traumatic Stress Disorder
RP	Registered Provider
SAFE	Specified Activity for Female Empowerment
SNA	Strategic Needs Assessment
TWW	Tomorrows Women Wirral
VIC	Veteran in custody
VICSO	Veteran In Custody Support Officer
YOI	Young Offenders Institution

APPENDICES – ***See Separate Document***

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