A health needs assessment of offenders in the community

Derbyshire and Derby City

FULL REPORT

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List of Abbreviations

ADHD	Attention deficit hyperactivity disorder
APMS	Adult Psychiatric Morbidity Survey
AsPD	Antisocial personality disorder
ATR	Alcohol Treatment Requirement
BBVs	Blood-borne viruses
BME	Black and minority
CCGs	Clinical Commissioning Groups
CMD	Common mental disorder
CRC	Community Rehabilitation Company
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DIP	Drug Interventions Programme
DLNRCRC	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company
DRR	Drug Rehabilitation Requirement
HNA	Health Needs Assessment
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
IOM	Integrated Offender Management
MHCCC	Mental Health Crisis Care Concordat
NPS	Derbyshire National Probation Service or National Probation Service
PHE	Public Health England
PHOF	The Public Health Outcomes Framework
SMR	Standardised Mortality Rate
STPs	Sustainability and Transformation Plan
TB	Tuberculosis
WHO	World Health Organisation
YOS	Derbyshire Youth Offending Service or Youth Offending Service

1.0 Introduction

1.1 Context

> *"Health inequalities experienced by people in contact with the criminal justice system are well above the average experienced by the general population. As well as those in a custodial setting, this includes offenders serving community sentences, those who are in the community on licence and those in contact with the criminal justice system on suspicion of committing a criminal offence. Evidence illustrates that as a group, those who have or are at risk of offending frequently suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality. These underlying health issues are often exacerbated by difficulties in accessing the full range of health and social care services available in the local community".*[3]
> *(Balancing act: addressing health inequalities among people in contact with the Criminal Justice System).*

This Health Needs Assessment (HNA) focuses on identifying the health needs of community offenders in the areas covered by Derbyshire County Council and Derby City Council. An appraisal of the health needs of community offenders in Derbyshire was requested by the Reducing Offending, Reoffending and Offender Health Board. The purpose of this was to provide evidence to support development of a strategic direction for improving the health of this population group and identify the subsequent actions required by services.

A HNA is a systematic method for reviewing the health problems faced by a population and results in an agreed list of priorities to improve health.[4]

Combined, Derbyshire County and Derby City cover a large geographical area, containing both urban and rural districts and encompassing much of the Peak District National Park. The total population is estimated to be 1,042,000, with approximately 256,230 residing in Derby City and 785,770 in Derbyshire County.

Overall, when compared with the indicators of health for the East Midlands and England, those of Derbyshire County are similar to the regional and national averages. There are however, areas of poor health in the more industrial districts in the northern part of the county. In addition, the relatively affluent appearance of the rural areas mask pockets of multiple deprivation. Health indictors for Derby City however, are worse overall than the regional and national averages.

1.2 HNA Rationale

Although there is much published literature on the health needs of offenders in prison, there remain many unanswered questions about the health needs of offenders in the community. There is a documented absence of literature on the health profile and needs of offenders in

community settings.[5] It is also unclear whether the needs of offenders accessing each of the various supervising organisations, such as Derbyshire National Probations Service (NPS), Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNRCRC) or the Derbyshire Youth Offending Service (YOS), differ and how offenders in the community can be best supported to improve both their mental and physical health and well-being. There is the potential to reduce reoffending behaviour by improving the health of this population group, for example by improving mental health or reducing substance misuse, but this cannot be achieved without understanding their health needs.

This HNA will fill several gaps in understanding by linking perceptions of need and experiences of services and by helping to identify the often unique healthcare issues relating to specific offender cohorts and their dynamic 're-offending' risk factors, such as substance abuse and negative peer associations.

1.3 Aims and Objectives

The overall aim of the HNA is to explore the health needs of offenders serving community sentences in Derbyshire and to identify any barriers to accessing health and social care services. The objectives are:

1) To identify the health needs of community offenders in Derby City and Derbyshire County, utilising both statistical information and through consultation with community offenders.
2) To compare the health of community offenders in Derby City and Derbyshire County with national and regional figures.
3) To identify gaps in service provision.
4) To highlight any specific barriers that restrict to access to health services for community offenders and identify ways in which referral pathways can be improved.
5) To identify where improvements can be made between custodial healthcare services and community-based provision.

1.4 Scope

This HNA considers the health needs of both male and female community offenders of all ages resident within the geographical areas of Derby City and Derbyshire County.

Community offenders are defined as those sentenced at either a magistrates' court or the Crown Court and either:

- Under probation supervision with DLNRCRC or NPS,
  or
- Under the supervision of either Derby City or Derbyshire County's YOS.

Offenders in custody (i.e. prison or police custody units) were excluded from this HNA as health services are commissioned separately for these groups of offenders. However, the HNA does consider pathways of care for offenders being released from prison into the community.

Non-statutory supervised offenders were also excluded because it was deemed that inclusion of offenders not currently known to offender services would had the potential to shift the

focus of the HNA away from the health of current offenders and how organisations (i.e. NHS commissioners and providers, offender services, Public Health and others can work to meet the needs of this population group.

1.5 Definitions

1.5.1 Community Offenders

The term offender is used to define an individual convicted in a court of law as having committed a crime, violated a law or transgressed a code of conduct.[6] There are three types of offenders who are managed in the community; these are offenders:

- serving community sentences;
- on suspended sentences; or
- on licence (the second part of a 'determinate' sentence, where part of it is served in prison and part on supervision in the community).[7]

1.5.2 Health and health needs

For the purpose of this report, health refers not only to physical and mental health but also to the wider determinants of health, such as the sociological and demographic aspects. Evidence demonstrates that wider aspects of an offender's health, such as lacking the confidence to visit a GP surgery or inappropriate living accommodation can impact the risk of offending.[8] The use of the term 'health and wellbeing' aligns with the World Health Organisation's definition of health as:

> "*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*."[9]

Health needs are often defined as a "capacity to benefit" and can be described in a number of ways:

- Perceptions and expectations of the profiled population (felt and expressed needs)
- Perceptions of professionals providing or commissioning a service (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (comparative needs).

1.6 Geographic terminology

For the purpose of this HNA, Derbyshire County refers to Derbyshire County only, Derby City refers to Derby City only and Derbyshire is used to refer to Derby City and Derbyshire County combined.

2.0 Policy

2.1 National Acts and Legislation

In 2005, as one of the provisions of the Criminal Justice Act, Community Orders were introduced as a sentencing option.[11] The Criminal Justice Act enables twelve requirements to be made as a condition of a community order with three deemed particularly relevant to health: Mental Health Treatment Requirement; The Drug Rehabilitation Requirement and Alcohol Treatment Requirement (ATR).

Mental Health Treatment Requirements provide a mechanism to ensure that community offenders with a mental health condition are able to access appropriate treatment.[12]

A DRR lasts between six months and three years and supports offenders to:

- Identify what they must do to stop offending and using drugs;
- Understand the link between drug use and offending, and how drugs affect health;
- Identify realistic ways of changing their lives for the better;
- Develop their awareness of the victims of crime.[13]

Alcohol Treatment Requirements (ATR) focus on community offenders who are either dependent on alcohol use, or alcohol use contributes to their offending.[14] The aim of an ATR is to reduce or eliminate the offender's dependency on alcohol.[15]

In 2012, the publication of the Health and Social Care Act[16] placed the responsibility for commissioning for health and wellbeing with NHS England, the Clinical Commissioning Groups (CCGs) and Local Authorities.

Additionally, Health and Wellbeing Boards (HWBs) were established under the Health and Social Care Act (2012), to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.

In 2014, The Offender Rehabilitation Act[17] made changes to the sentencing and release framework to create greater flexibility in the delivery of sentences served in the community.

The Care Act[18] provides legislation on assessing and providing for the social care needs of eligible people leaving prison, living in bail accommodation or living in approved premises. Assessments under the Act are the responsibility of Local Authorities.

2.2 National policy, strategy and reports

In 2007, The Local Government and Public Involvement in Health Act[19] was published, which requires local authorities to produce a joint strategic needs assessment (JSNA) of the health and wellbeing of their local community. JSNAs are used to establish the current and future health needs of a local population and provide indicators to support better targeting of interventions to reduce health inequalities.

Published in 2009, Lord Bradley's review[20] recognised that many offenders pose no risk to the public and could be better treated outside the prison system. The Prison Reform Trust called on the government to implement Lord Bradley's recommendations without delay. The Review also called for a new national strategy for rehabilitation services to be developed for the group of petty offenders with mental health problems or learning disabilities to ensure they are helped to stay out of trouble. The Bradley Report emphasises the importance of continued provision of mental health and social care services after release from prison. To assist with resettlement, on release from prison an adult offender is supervised by a probation officer from either a CRC or the NPS. Amongst other responsibilities, the role of the probation officer is to help the offender with any problems, such as housing, mental health and drugs or alcohol misuse.[21]

In 2012, the Government's Alcohol Strategy was published, which makes specific reference to the needs of offenders dependent on alcohol.[22] The Alcohol Strategy acknowledges the high prevalence among the offender population of drinking at higher risk levels and states a need to ensure that entry into the criminal justice system provides an opportunity to provide support to overcome alcohol problems and prevent further offending.

In 2013, The Balancing Act highlighted three reasons why Directors of Public Health should prioritise the health of people in contact with the criminal justice system:

1) Addressing the health needs of people in contact with the criminal justice system will enable Directors of Public Health to meet key national targets to improve the health of the most vulnerable.
2) Working to reduce reoffending and create safer communities will have health benefits for the wider population.
3) Collaborative working with NHS England commissioners will help to improve health outcomes by strengthening pathways between custody and the community.

In 2014, 22 national bodies signed the Mental Health Crisis Care Concordat (MHCCC), a national agreement between services and agencies including health, criminal justice and local authorities involved in the care and support of people in crisis.[23] The Concordat aims to improve responses to people in mental health crisis, many of whom come into contact with the police.[24] A core principle of the Mental Health Concordat is to provide access to support before crisis is reached. This could include "*access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence and are in police custody or going through court proceedings*."

In 2016, the Five Year Forward View for Mental Health was published, containing a cross-government commitment to improve pathways for those affected by mental ill health.[25] The recommendations set out in the Five Year Forward View for Mental Health are supported by the strategic document published in 2016.[2] The report recommended that mental health services should be improved, with continuity of care on release to support offenders returning to the community.

In 2016, NHS England published the document '*Strategic direction for health services in the justice system 2016-2020*'; [2] this sets out seven priority areas that NHS England will focus on to reduce the health inequalities experienced by individuals known to the criminal justice system:

1) A drive to improve the health of the most vulnerable and reduce health inequalities
2) A radical upgrade in early intervention
3) A decisive shift towards person-centred care that provides the right treatment and support.
4) Strengthening the voice and involvement of those with lived experience.
5) Supporting rehabilitation and the move to a pathway of recovery.
6) Ensuring continuity of care, on reception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings.
7) Greater integration of services driven by better partnerships, collaboration and delivery.

In 2017, Rebalancing Act[24] was published as a follow up to The Balancing Act to support stakeholders at all levels to understand and meet the needs of individuals in contact with the criminal justice system and through this to address health inequalities experienced by offenders. This report called for implementation of the following straightforward approach to services:

- Build understanding of the specific health needs of people in contact with the criminal justice system locally;
- Engage with communities, including service users and those with lived experience;
- Commission and deliver programmes jointly with partners across the system, including developing early intervention and prevention programmes; and monitor and evaluate progress and change.

2.3 Local policy, strategy and reports

2.3.1 Sustainability and Transformation Partnerships

Sustainability and Transformation Partnerships (STPs) were introduced in 2015 to provide 'place-based plans' for the future of health and care services and to support implementation of the Five Year Forward View. STPs provide the NHS with an opportunity to work closely with local government and other local partners to develop new ways of providing high quality health care.

Derbyshire's STP, *Joined Up Care Derbyshire,* published in 2017, brings together work that has been taking place across the county to coordinate services better to support people in staying well. Derbyshire's STP details that the NHS and social care partner organisations working on Joined Up Care Derbyshire will look at improving how they work together, supporting people who are most at risk and making sure health and social care professionals get the best opportunities to help people lead happier healthier lives. It also states that services will focus on looking after people in their home or local area and preventing illness by helping people to

take good care of themselves and deal with issues before they become better problems. This highlighted five priorities:

1. To do more to prevent ill health and help people take good care of themselves.
2. To tailor services so they look after and focus on people in their communities, so people get better, more targeted care and support.
3. To make it easy for people to access the right care, whenever it is needed, so everyone gets better quality, quicker support across the system. This would help keep Accident & Emergency, Minor Injury Units and Urgent Care Centres free for patients who really need them.
4. To get health and social care working seamlessly together so people get consistently high quality, efficient, coordinated services, without gaps or duplication.
5. To make organisations as efficient as possible so money is pumped into services and care, with running costs kept low.[27]

2.4 Context of current service provision in Derbyshire

The multiple and complex needs of community offenders often prevent any organisation from single-handedly being able to address their needs.[24] In Derbyshire, a number of services are responsible for working with offenders in the community.

2.4.1 Healthcare commissioning

Since April 2013, CCGs have been responsible for commissioning the majority of community and acute health services (including mental health services).[11] CCGs commissioning responsibilities include:

- Planning services, based on assessing the needs of their local population
- Securing services that meet those needs; and
- Monitoring the quality of care provided.

In Derbyshire, there are five NHS Clinical Commissioning Groups (CCGs); Southern Derbyshire CCG, North Derbyshire CCG, Erewash CCG, Hardwick CCG, and Tameside and Glossop CCG. Therefore, Derbyshire CCGs have responsibility for commissioning health services for community offenders as members of the local population. Derbyshire CCGs do not commission specialist health services for offenders in the community.[6,7]

2.4.2 Mental health services

Derbyshire Healthcare NHS Foundation Trust (DHcFT) provide services to people experiencing mental health problems. This includes a specialist criminal justice mental health team which provides an innovative screening service available at several points within the Criminal Justice System. This allows early detection and assessment of offenders with mental health problems to ensure appropriate and effective outcomes. The criminal justice mental health team assess people in police custody and magistrates courts at Derby, Chesterfield and Buxton police stations, and Derbyshire probation services. The team identifies the needs of an individual such as whether they are on a Care Programme Approach, suffering from a severe mental health problem or need to be assessed under the Mental Health Act.

Improving Access to Psychological Therapies (IAPT) are available to those experiencing common psychological conditions, such as those feeling anxious, low or depressed. There are three IAPT providers within Derbyshire: Talking Mental Health, Insight Healthcare and Trent PTS.

2.4.3 Public Health commissioned and provided services

Responsibility for commissioning public health services lies with Derby City Council and Derbyshire County Council.[11] Services that Public Health teams in Local Authorities are responsible for commissioning include sexual health, substance misuse, lifestyle, school nursing, and NHS Health Checks.

Within Derbyshire, there are no Public Health services specifically commissioned or provided for offenders in the community. However, all commissioned services should target those population groups with greatest need and capacity to benefit, which may include community offenders.

2.4.4 Offender management services

2.4.4.1 Policing services

Derbyshire Police provide policing and enforcing services across Derbyshire, including assessing clients on arrival in custody for drugs, and appropriate signposting for treatment services.

2.4.4.2 Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company

Established in June 2014, the DLNRCRC is responsible for managing low and medium risk offenders in the community. DLNRCRC's top priority is to reduce re-offending and improve public protection. DLNRCRC staff assist with sentence planning and conditions which stipulate where the offender should live, whom they may or may not see, and compulsory attendance on programmes such as anger management.

2.4.4.3 Rehabilitation services provided by the National Probation Service

Established in June 2014, the NPS works in partnership with CRCs, and private and voluntary sector partners in order to manage offenders safely and effectively. NPS' priority is to protect the public by the effective rehabilitation of high risk offenders, by tackling the causes of offending and enabling offenders to turn their lives around. NPS is responsible for managing high risk offenders (offenders who pose the highest risk of serious harm to the public and who have committed the most serious offences) in the community. This includes the rehabilitation and management of all high risk offenders in the community, including making sure they meet any court requirements. This also involves managing approved premises (where offenders are required to stay in specified accommodation as part of their sentence).

2.4.4.4 Youth Offending Services

Youth Offending Services (YOS) are multi-agency services which aim to prevent and reduce re-offending by young people. YOS aims to help prevent further offending by supervising and supporting young people and working with them.[30] YOS works as a partnership between local authority children services department (including the education service), the local constabulary, the local probation trust and the NHS.[30]

Derbyshire YOS works with young people aged 10 to 17 and their communities to tackle youth crime in Derbyshire, and Derby City YOS fulfils a similar role to prevent and reduce offending by young people in Derby City Derbyshire and Derby City YOS are both partnerships between the Children Services Department (including the education service), Derbyshire Police, Probation services and the local NHS.[30,31]

2.4.4.5 Integrated Offender Management

In 2011, Derbyshire implemented Integrated Offender Management (IOM). IOM was developed as a joint collaboration between Derbyshire County Council, HM Prison Service, DLNRCRC, NPS and Derby City Council Neighbourhood Partnerships; united by their aim of reducing re-offending and reducing the number of victims, benefit local communities, the general public and the offenders themselves.[28] Derbyshire's IOM scheme focuses on offenders, not offences, with the purpose of improving the sharing of information between criminal justice agencies and other partners and enhance collaborative working to control, manage and supervise a group of offenders who are assessed as being highly likely to re-offend.[29]

3.0 Methodology

3.1 Overview of HNA process

An HNA is a systematic process to assess the health problems facing a population. This HNA was designed using the three main methods of epidemiological, comparative and corporate assessment. The epidemiological needs assessment includes quantitative analysis of morbidity and mortality of offenders in Derbyshire. The comparative needs assessment contrasts morbidity amongst Derbyshire community offenders to morbidity amongst the general population in Derbyshire and in other areas of England. The corporate needs assessment provides qualitative evidence from key stakeholders to inform the HNA.

A participative methodology was adopted to yield an overview of the community offender population and their health needs. The HNA employed a mixed-methodology utilising primarily qualitative sources in addition to some descriptive data analysis and service mapping to identify community offenders' need, assess how current service provision meets need, and identify possible priorities for joint action.

3.1.1 HNA Steering Group

A steering group provided oversight for this HNA and consisted of the following members:

- Rosie Cooper, Specialty Registrar in Public Health, Derbyshire County Council
- Christine Flinton, Head of Community Safety, Derbyshire County Council
- Iain Little, Assistant Director of Public Health, Derbyshire County Council
- Rosemary Spilsbury, Business and Performance Manager, Derbyshire Criminal Justice Board

3.2 Project steps

A four stage approach was devised, detailed in Figure 1 below.

Figure 1: Four stage approach to NHA

Stage	Tasks include
Stage One: **Mapping and Scoping**	• Conducting literature reviews, summarising relevant findings from other HNAs, other local studies and policy documents. • Assessment of available relevant data sources. • Preparation of fieldwork 'proforma' and interview resources. • Discussion of proforma for interviews and surveys with stakeholders. • Collation of available quantitative data.
Stage Two: **Fieldwork**	• Piloting of questionnaires and interviews • Acquiring data from key stakeholders (including community offenders) by interview and survey to identify priority health issues, barriers to accessing services and barriers to delivering services.
Stage Three: **Analysis**	• Analysis of data obtained from stakeholders. • Analysis of available quantitative data.
Stage Four: **Presentation of findings**	• Drawing conclusions from data and drafting recommendations.

3.3 Stage One – Scoping

3.3.1 Literature review

A literature search was carried out in January 2017 and was regularly updated over the course of the research to investigate existing literature on the health needs of community offenders. The review was conducted searching PychINFO; EMBASE; HBE; PubMed; BNI; CINHAL; HMIC; Medline and Cochrane Systematic Reviews, using appropriate search terms. Searches were limited to the years 2000 to 2017 (deemed most relevant) and to English language publications only. Google and Google Scholar search engines were also searched for grey literature, deemed particularly important in this field due to the likelihood of similar HNAs being available online.

3.4 Stage Two – Fieldwork

3.4.1 Quantitative methodology – Derbyshire Community Offenders

To conduct the quantitative analysis a questionnaire was developed by the author in consultation with the HNA steering group (see Appendix 1). Decisions on the content of the

questionnaire were informed by the health needs of offenders identified in the literature and by previous offender HNAs.

The questionnaire was designed to elucidate the health needs of community offenders:

- to determine which services they required (both whilst serving an entire community sentence and following release from prison);
- to determine how easy offenders find it to access services; and
- to capture their opinion of the care provided in terms of usefulness and satisfaction.

To assess the appropriateness of the questionnaire, it was first piloted with 13 community offenders in Derbyshire. The piloted questionnaire required few changes, and these responses have therefore been included in the final analysis.

The cohort of offenders in the community was sampled using convenience sampling. 320 questionnaires were sent to NPS, DLNRCRC and YOS, together with a consent form and an accompanying information sheet to distribute to their case workers. Each case worker was asked to ensure that survey participants signed the consent form before completing the questionnaire.

To preserve the confidentiality of the responses, a return envelope was provided with each questionnaire so that all respondents could seal and return their completed questionnaires directly to Derbyshire County Council. The returned questionnaires were transferred to electronic media for analysis.

Not all respondents completed every question and therefore, for the purposes of this HNA, those with missing responses have been excluded from the denominator for each individual question where appropriate. It should be noted that the denominator therefore differs between questions.

To provide contextual information for the HNA, each service (DLNRCRC, NPS and YOS) was also asked to provide a set of demographic data for their current service users.

3.4.2 Qualitative methodology

The corporate needs assessment employed a qualitative methodology to capture the views of offenders themselves, of health care staff in contact with offenders and of offender case workers. This consisted of qualitative interviews, the schedule for which is included in Appendix 2 and an online survey, which is shown in Appendix 3.

3.4.2.1 Online questionnaire for health staff

A link to an online questionnaire (Appendix 3) was circulated to offender case workers employed by YOS, DLNRCRC and NPS and also to professionals working in services providing health care to offenders during April and May 2017.

The aim was to gather information about existing service provision and identify areas for improvement locally. Staff working with offenders in the community were asked for their views on five main topics:

- Health issues experienced by offenders;
- Offenders access to health services;
- Health issues offenders do not seek help for;
- Reasons for offenders not seeking help; and
- How services could be improved.

3.4.2.2 Interviews with community offenders

In order to obtain richer data, DLNRCRC, NPS and YOS staff were asked to conduct semi-structured interviews with respondents using an interview schedule (Appendix 2). Convenience sampling was again used to identify participants. The first three interviews were completed as pilots. Discussions about the acceptability and feasibility of these interviews with the probation professionals concluded that no any major changes to the process were required. The three pilot interviews have therefore been included in the final dataset. DLNRCRC, NPS and YOS staff recorded participants responses on the interview schedules.

3.5 Stage Three: Analysis

3.5.1 Comparative methodology analysis

Analysis of the results from Derbyshire's community offender's questionnaire carried out for this HNA are shown below and, where appropriate, compared to the health of the general population in Derbyshire.

Existing evidence on community offender health needs was identified through a literature review, undertaken to inform this HNA. Sources of data on the health of community offenders are limited and comparators have therefore been drawn from offender HNAs carried out in other regions of England.

3.5.2 Corporate methodology analysis

3.5.2.1 Analysis of online questionnaire for professionals and interviews of community offenders

All interviews were transcribed verbatim by a Derbyshire County Council employee. Interviews and responses to the questionnaire were analysed thematically, adopting a social constructivist perspective. This meant that thematic analysis was undertaken at the latent level, exploring the underlying concepts inferences and suppositions of responders. Initially, the author immersed herself in the data, noting preliminary patterns and meaning. The analysis progressed from description, to a latent-level analysis combing codes to produce subthemes. Subthemes were summarised, combined and classified into themes.

3.5.2.2 Reflexivity

The researcher who analysed the data was an NHS professional, which may have introduced professional bias. Furthermore at the time of writing they were placed at Derbyshire County Council. To address bias and improve validity, the themes identified were reviewed by a member of the steering group (also an employee of Derbyshire County Council). Discrepancies were reviewed but resulted in only minor amendments to identified themes.

4.0 Results

4.1 Literature review on mortality and morbidity in offenders

4.1.1 Mortality

In comparison to studies examining the mortality of offenders in prison, only a paucity of evidence of mortality in offenders in the community exists.[32] However it is known that community offenders have an extraordinarily high rate of mortality, through which a high prevalence of health problems can be inferred.[33] In 1997, male community offenders were reported to have a death rate of 464.0 per 100,000, in stark contrast to the death rates of 107.5 for males in the general population.[32] The highest rates of death in community offenders were attributable to 'suicide/self-inflicted injury' and 'accident/misadventure'.[32]

4.1.2 Morbidity

Among the community offender population, many experience significant issues with morbidity such as physical and mental health and substance misuse problems, often complicated by social issues such as unemployment, indebtedness, homelessness or social isolation.[24]

Although few studies have examined the health of community offenders, research indicates that their health is more similar to that of prisoners rather than that of the general population.[5]

4.1.2.1 Mental Health

Mental illness includes schizophrenia, bipolar disorder, drug-induced psychosis, personality disorder, depression, anxiety and post-traumatic stress disorder. Whilst literature on the mental health of prisoners exists, few studies explicitly detail the mental health of community offenders, although many authors have suggested the needs of community offenders to be similar to those of offenders in prison. [33]

The offending population frequently experience poor mental health, often associated with a lifetime of social exclusion and the consequences of social exclusion.[34] Mental health, drug dependency and chronic social exclusion are often inter-related problems of offending.[34] Young offenders have been found to have high levels of needs in areas such as mental health (31%), education/work (36%) and social relationships (48%).[35] A further study collecting information via semi-structured interviews and questionnaires amongst young offenders aged 10-17 attending a community Youth Offending Team identified potential mental health problems requiring further specialist assessment in 57% of those assessed.[36]

It is widely reported that many offenders in the community need support for their mental health[37] and will be unlikely to engage with health services to seek this.[6]

4.1.2.2 Drugs and alcohol

Evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary.[38] It is probable that problem drug users will end up in the criminal justice system at some point as a direct consequence of the crimes they commit.[38] In 2008, the National Treatment Agency for Substance Misuse estimated that at least a quarter of the adults in contact with the community treatment services were identified via the criminal justice system.[38]

A descriptive study on the health needs of young offenders aged 10-17 attending a community Youth Offending Team found that alcohol was consumed more than twice per week by 68%, with 47% having recently smoked cannabis, and 11% recently using heroin, methadone or crack cocaine.[36]

Although it usually takes many years to help an individual overcome addiction, treatment is reported to have an immediate impact on their offending.[38] Following the start of treatment, the number of offences opiate and cocaine users committed almost halved, with up to half the offenders ceasing to offend completely, reducing the harm offenders cause to themselves, their families, communities and wider society.[38]

The National Treatment Agency for Substance Misuse report that both the availability of drug treatment for offenders in the community and the quality of that treatment have improved a great deal over the past decade.[38] This has been achieved through the introduction of the Drug Interventions Programme (DIP) and the Drug Rehabilitation Requirement (DRR).[13]

Alcohol consumption does not inevitably result in crime and disorder, however there is a certain association between alcohol and crime. Almost half of victims of violent crime (violence, injury and victimisation and also domestic violence and sexual assault) say the perpetrator was under the influence of alcohol at the time.[15]

In 2004, the Prison Reform Trust recommended that effective screening tools should be implemented to identify hazardous drinkers as they are received into custody.[15] Whilst there is little evidence on the effect of alcohol specifically on offenders in the community, it is thought that without thorough care, prisoners who have committed alcohol-related crimes are at serious risk of re-offending.[15]

4.1.2.3 Smoking

The prevalence of smoking among the offender population is reported to exceed that of the general population[5] Smoking rates may be higher in offenders than the general population because they are more likely to come from deprived communities and experience greater health inequalities.[39] The transient nature of offenders often makes it difficult to offer joined-up support to offenders to quit smoking.[39]

4.1.2.4 Communicable diseases

Primary care providers strive to ensure the general population is up to date with their immunisations.[40] However it is perceived by professionals that offenders in the community may have difficulty engaging in primary care services due to their chaotic lifestyle and difficulties in communication.[41] It is possible that custody and interaction with the criminal justice system may represent an opportunity to engage with normally excluded populations and can offer opportunities for:

1) Diagnostic testing as part of screening or active case finding programmes, e.g. cervical screening programmes, testing for blood-borne viruses (BBVs) and tuberculosis (TB).
2) Vaccination against infectious diseases e.g. hepatitis B.
3) Access to primary and specialist care services for the management of diagnosed infectious diseases e.g. HIV, hepatitis C, TB and sexually transmitted infections.[40]

4.1.3 Use of health services

Community offenders have access to the same healthcare services as the rest of the local population.[11,42] However, it is recognised that community offenders have difficulty accessing health services and tend to over-use crisis services such as Accident and Emergency.[5] A descriptive study of young community offenders (aged 10-17) found that almost half had had no contact with the GP in the past year.[36]

4.1.4 Evidence of effectiveness of interventions for community offenders

Whilst evidence on the effectiveness of interventions for offenders does exist, much of what there is focusses on the prevention of re-offending and/or the health of prisoners. The evidence base around the effectiveness of interventions for improving the health of community offenders does not appear to be extensive and much of what there is relates to reducing subsequent re-incarceration, which may not be applicable.

The handful of studies which suggest a possible effect on an area of community offender health tend to lack robustness due to small numbers of trial participants in observational studies, leading to reduced external validity and thus limiting the conclusions to be drawn.

Whilst the studies included below explore health conditions which the author perceives may also be applicable to the offender population, it is possible that some may also lack external validity and may not have been conducted entirely within a community offender population group.

The lack of high quality evidence highlights a clear need for further research in this field. As this summary specifically considers the health needs of community offenders, papers which did not explicitly investigate a subject related to health, such as those that studied subsequent recidivism, were deemed not to be relevant and consequently disregarded.

A Cochrane review focusing on interventions for drug-using offenders with co-occurring mental illness studied the effectiveness of the interventions in reducing criminal activity or

drug use, or both. The review found that two out of five trials showed some promising results for the use of therapeutic communities and aftercare in relation to reducing subsequent re-incarceration only.[43] However, these findings warranted a degree of caution in their interpretation due to a high degree of variation and possible lack of generalisability to the community offender population.

A further study reviewed pharmacological interventions aimed at reducing drug use or criminal activity, or both, for illicit drug-using offenders.[44] The authors found that when compared to non-pharmacological treatment, agonist treatments were not effective in reducing drug use or criminal activity. Antagonist treatments were also not effective in reducing drug use but did significantly reduce criminal activity. However, caution should again be applied when interpreting the findings of this study as the majority of included studies investigated only male adult offenders. Also many of the included studies were rated as being at high risk of bias and conclusions were based on small numbers of trials.

In 2010, Gibbon et al.,[45] conducted a systematic review into psychological intervention for antisocial personality disorder (AsPD). The authors concluded there is insufficient trial evidence to justify using any psychological intervention for adults with AsPD. They identified three interventions, contingency management with standard maintenance, cognitive behavioural therapy with standard maintenance and the 'Driving Whilst Intoxicated program' with incarceration, which appeared to be effective in terms of improvement in at least one outcome in at least one study when compared to the control condition. Each of these interventions had originally been developed for people with substance misuse problems. Significant improvements were mainly confined to outcomes related to substance misuse. The authors found no studies that reported significant change in any specific antisocial behaviour and recommended further research is needed in this area.

A further study in 2010 by Gregory et al., investigated the effect of a speech and language intervention with a group of persistent and prolific young offenders in a non-custodial setting with previously undiagnosed speech, language and communication difficulties.[46] The study found that 65% of all those screened had profiles indicating that they had language difficulties and might benefit from speech and language therapy interventions. The authors studied a group of persistent and prolific young offenders sentenced to the Intensive Supervision and Surveillance Programme and found that this group as a cohort had lower language skill than the general population. This paper concluded that children and young people with behavioural or school difficulties coming into contact with criminal justice services should be systematically assessed for undiagnosed speech, language and communication difficulties. The paper suggests that further research is needed to determine the precise role of speech and language therapy within the intervention programme; however, they note that appropriate interventions can enable offenders to engage with verbally mediated interventions.

In 2012, Morgan et al.,[47] synthesised the available research on the treatment of offenders with mental illness. Whilst their meta-analysis results were based on a small sample of

available studies, their conclusions suggested that interventions for offenders with mental illness effectively reduced symptoms of distress, improving offender's ability to cope with their problems and resulting in improved behavioural markers.

4.1.5 Gaps in literature

Whilst this HNA focuses on the needs of offenders in the community, parallel research projects have been undertaken on prison population and locally on the needs of the general population. It is acknowledged that the majority of literature in this area may not be transferable to community offenders. However, as community offenders will transition either from, or to, these population groups it is imperative that the findings of all these projects are considered concurrently to fully comprehend the local needs of those coming into contact with the criminal justice system. Until recently, policy required almost all offenders to be incarcerated. Therefore it is presumed that regarding physical health, mental health and substance misuse the needs of community offenders would be similar to those of prisoners, although access to services differ.

There is a paucity of research specifically exploring the health needs of community offenders and considering the effectiveness of services to improve health in this population. It was concluded that further research would be required on the subject of offender health to aid development of a comprehensive understanding of their health needs and service requirements.

4.2 Public Health Outcomes Framework indicators

Public Health England (PHE) provides Public Health Profile data tools and the Public Health Outcomes Framework (PHOF),[48] which include indicators for both first-time offenders and reducing re-offending levels as well as detailed annual local substance misuse reports. PHE also produces tailored support packs which, although not in the public domain, are sent directly to the offices of each Association of Police and Crime Commissioner.

The PHOF includes indicators for first time offending rates and for the proportion who re-offend by local authority areas. Local data are shown below in Figure 2.

First time offending rates are significantly higher in Derby City than those seen regionally or nationally, but significantly lower in Derbyshire County.

The percentage of offenders who re-offend is higher in Derby City than that seen regionally or nationally; however, in Derbyshire County the percentage who re-offend does not differ significantly from that seen either regionally or nationally.

Figure 2: First time offending and re-offending

Indicator	First time offenders		Re-offending levels	
	Number	Crude rate / 100,000 population	% of offenders who re-offended	Average number of re-offences per offender
Period	**2016**		**2014**	
Derbyshire County	1,362	174.1	24.2	0.75
Derby City	720	283.2	29.4	1.02
East Midlands	9,865	210.9	25.1	0.81
England	119,641	218.4	25.4	0.82

Source: Public Health Outcomes Framework[48]

4.2.1 Offenders in the community in Derbyshire

In Derbyshire, three main organisations work with community offenders:

- NPS
- DLNRCRC
- YOS

At August 2017, there were 3,659 offenders being managed in the community in Derbyshire. The majority of these were under the supervision of DLNRCRC and classified as low-medium risk. There were just over 400 offenders aged under 18, making up approximately 11% of the cohort of offenders supervised in the community.

Figure 3: Offenders in the community managed by YOS, NPS and DLNRCRC, by area of residence

	YOS		NPS		CRC		Total	
Geography	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Derby City	157	4.3	475	13.0	1,032	28.2	**1,664**	**45.5**
Derbyshire County	256	7.0	482	13.2	1,257	34.4	**1,995**	**54.5**
Derbyshire	**413**	**10.4**	**957**	**24.2**	**2,289**	**65.4**	**3,659**	**100.0**

Source: Data provided by individual services; YOS & NPS 2017, DLNRCRC 2018

Figure 4 below provides an overview of the gender distribution of service users for each organisation. It can be seen that males are in the majority across all three services, making up 87.0% of the cohort.

Figure 4: YOS, NPS and DLNRCRC service users, by gender

	YOS				NPS				CRC				Total
	County		City		County		City		County		City		Derbyshire
Gender	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Males	210	5.7	131	3.6	460	12.6	454	12.4	1,030	28.1	897	24.5	**3,182**	**87.0**
Females	46	1.3	26	0.7	22	0.6	21	0.6	227	6.2	135	3.7	**477**	**13.0**
Persons	**256**	**7.0**	**157**	**4.3**	**482**	**13.2**	**475**	**13.0**	**1,257**	**34.4**	**1,032**	**28.2**	**3,659**	**100.0**

Source: Data provided by individual services, YOS & NPS 2017, DLNRCRC 2018

4.3 Offenders survey results

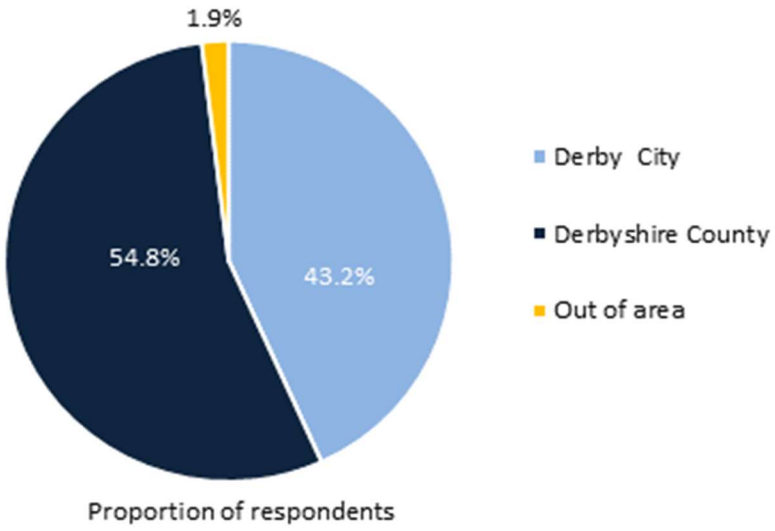
4.3.1 Demographics

4.3.1.1 Geographical location of respondents

Information about their location was not provided by 11 respondents (6.6% of 166). Of those who responded, 98.1% (152 of 155) stated that they lived within Derbyshire and 1.9% (3 of 155) reported living out of area. The proportion of respondents resident in Derbyshire County was higher than that resident in Derby City, with 85 (54.8%) residing within Derbyshire County and 67 (43.2%) within Derby City.

The geographical breakdown of survey respondents is closely similar to that reported by the services managing offenders in the community in Derbyshire and shown in Figure 3 above.

Figure 5: Geographical location of respondents



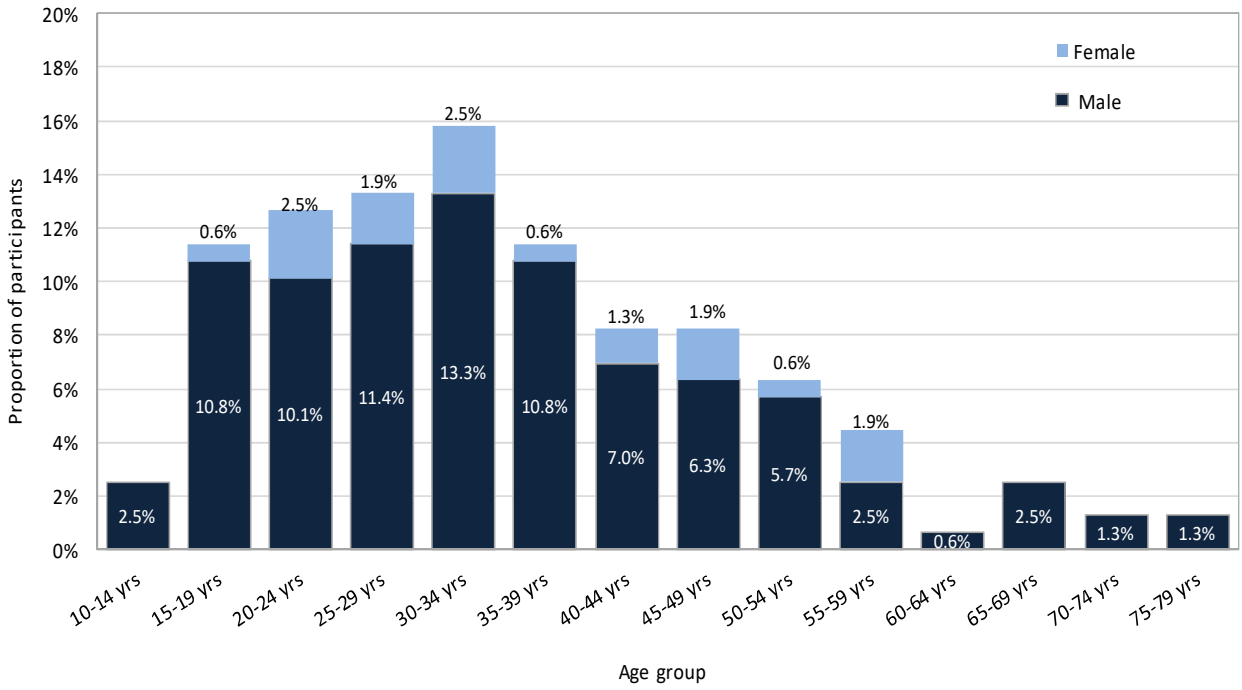
4.3.1.2 Gender of respondents

Information about gender was not provided by 4 respondents (2.5% of 166). The majority of respondents (86.3%, 140 of 162), were male, with females making up 13.6% (22 of 162) of the cohort. These proportions are similar to the gender breakdown for all offenders in the community in Derbyshire as shown in Figure 4 above.

4.3.1.3 Age distribution of respondents

8 (4.8% of 166) survey respondents did not provide their age. The distribution of age groups across respondents are shown in Figure 6 below by gender.

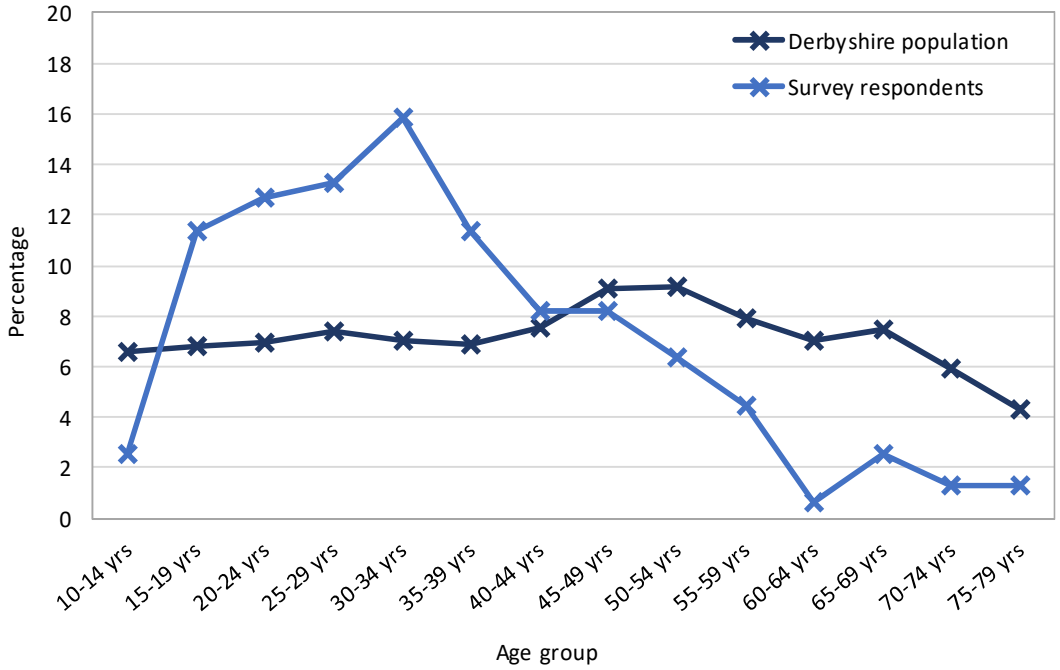
Figure 6: Survey respondents, by gender and age group



Whilst there are very small numbers in every age group, the majority of male respondents were aged 15 to 39 years (89 of 136, 65.4%). Numbers in each age group are even smaller for females, were the ages of respondents lying between 15 and 59 years with no obvious peak.

The age profile of survey respondents is compared to that of Derbyshire's population in Figure 7 below. It should be noted that community offenders have a much younger profile than that of the area's population overall.

Figure 7: Comparing the age profiles of survey respondents and the Derbyshire population



Source: Mid-2016 Population Estimates, ONS 2017

The age profile of survey respondents more closely resembles that of Derby City, which is known to be younger then Derbyshire County, but is still younger than the general population of either area.

4.3.1.4 Ethnicity of respondents

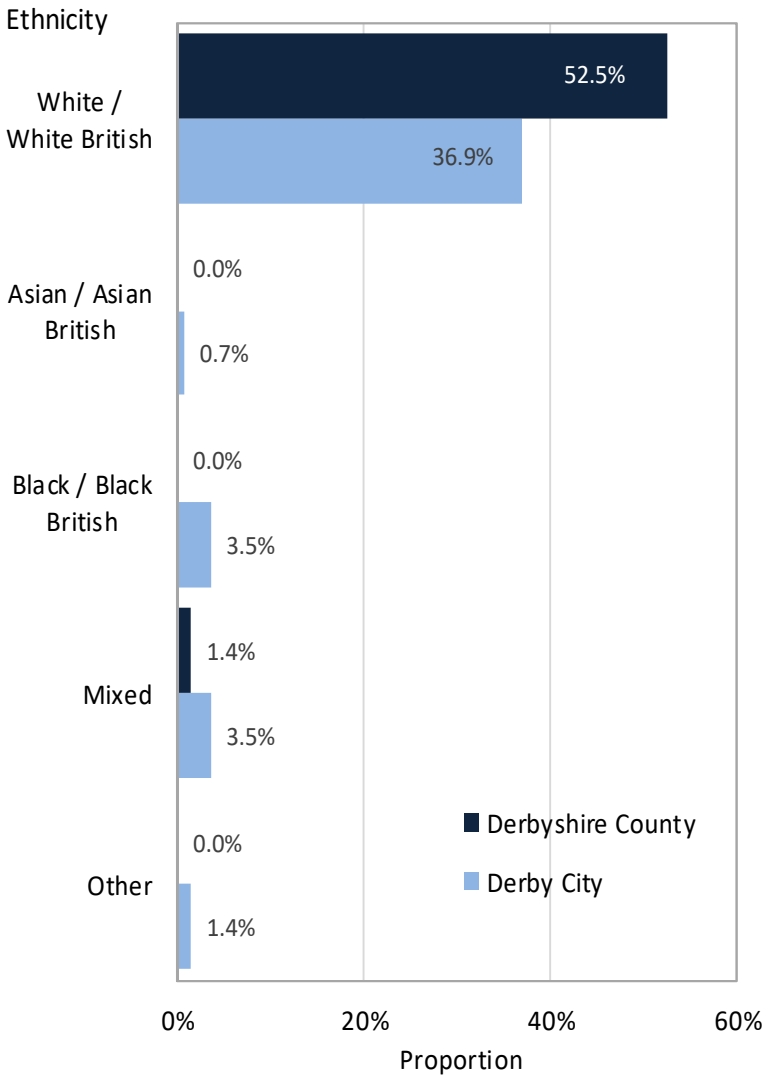
16 respondents (9.6% of 166) did not provide information about their ethnic origins.

The ethnic origins of respondents reflect those of the general Derbyshire population, with individuals of White / White British origin making up 88.1% (133 of 150) of the cohort compared to 93.3% of the general population.[49]

However, in the survey cohort the proportion of respondents from black and minority (BME) backgrounds was slightly higher 11.3% (17 of 150) than the 6.7% seen in the Derbyshire population overall.[49] All but 11.8% (2 of 17) of these respondents were resident in Derby City, reflecting the greater ethnic diversity of this population.

Figure 8 below shows the ethnic breakdown of respondents by geographical location for 141 respondents who provided both their ethnic origin and their location.

Figure 8: Ethnic breakdown of survey respondents



4.3.1.5 Disability of respondents

In the survey cohort, 9.0% (14 out of 156) of respondents classed themselves as disabled. This is higher than the 4% of the general population who defined themselves as disabled in the 2011 Census of Derby City and Derbyshire County.

The majority of disabled respondents, 64.3% (9 of 14), were resident in Derbyshire County, with just 14.3% (2 of 14) resident in Derby City. Of the respondents who regarded themselves as disabled, 3 (21.4%) did not provide their location.

4.4 Lifestyle

4.4.1. Smoking amongst community offenders

Respondents were asked whether they smoked cigarettes or tobacco and if so, how many cigarettes they smoked per day. 95.8% (159 of 166) of the cohort provided a response.

Of those that responded, 63.5% (101 of 159) described themselves as smokers. This is a much higher prevalence than was seen either nationally (15.5%) or locally amongst the general populations of Derby City (17.6%) and Derbyshire County (13.9%) in 2016.[50]

Amongst respondents resident in Derby City, 72.7% (48 of 66) of the cohort said they were current smokers or had in the past smoked, compared to 54.9% (45 of 82) in Derbyshire County. Although the proportion of smokers amongst respondents resident in Derby City was higher than amongst those resident in Derby County, the difference was not statistically significant.

4.4.1.2 Smoking prevalence, by gender

Of the 101 respondents who reported that they were current smokers, 100 (99.0%) provide information about their gender. 65.5% (91 of 139) of the male respondents described themselves as smokers compared with 47.4% (9 of 19) of female respondents who stated they were smokers.

Although a higher proportion of male respondents were smokers than was seen amongst female respondents, the difference was not statistically significant.

4.4.1.3 Smoking prevalence, by age group

96 (95.0%) of respondents who were current smokers provided information about their age. As can be seen in Figure 9 below, the greater majority of smokers were at the younger end of the age spectrum, with 29.2% (28 of 96) being aged 15 to 24 years and a further 34.4% being aged 25 to 34 years.

The young age profile is emphasised by the fact that 90.0% of the respondents managed in the community by YOS stated they were smokers, compared to 55.6% and 63.7% managed by NPS and DLNRCRC respectively.

This is of particular concern because adolescence is a time of rapid neurocognitive and hormonal change, making young people particularly vulnerable to smoking initiation and nicotine addiction. [51,52].

Starting to smoke at an early age has also been associated with heavier smoking in later life.[53]. This means that adolescent smokers will be at increased risk of the later life health hazards associated with smoking, such as respiratory and cardio-vascular disease.

Figure 9: Smoking prevalence, by age group

Age group	Smokers		Non-smokers	
	Number	%	Number	%
10-14 yrs	3	3.1%	1	1.7%
15-19 yrs	14	14.6%	4	6.9%
20-24 yrs	14	14.6%	6	10.3%
25-29 yrs	16	16.7%	5	8.6%
30-34 yrs	17	17.7%	8	13.8%
35-39 yrs	8	8.3%	10	17.2%
40-44 yrs	11	11.5%	2	3.4%
45-49 yrs	3	3.1%	8	13.8%
50-54 yrs	5	5.2%	4	6.9%
55-59 yrs	1	1.0%	5	8.6%
60-64 yrs	0	0.0%	1	1.7%
65-69 yrs	3	3.1%	1	1.7%
70-74 yrs	0	0.0%	2	3.4%
75-79 yrs	1	1.0%	1	1.7%
All ages	**96**	**100%**	**58**	**100%**

4.4.1.4 Tobacco consumption

Survey respondents were asked about the number of cigarettes they smoked in a day. The majority of smokers, 66.3% (67 of 101), reported that they smoked between 5 and 20 cigarettes a day (Figure 10).

Figure 10: Cigarettes smoked per day

Cigarettes per day	Number of respondents	Percentage
Less than 5	14	13.9%
5-10	36	35.6%
11-20	31	30.7%
21-30	13	12.9%
Over 30	3	3.0%
Not specified	4	4.0%
	101	100%

4.4.1.5 Quit attempts

Respondents who were smokers were asked whether they had ever tried to stop; although 61.4% (62 of 101) stated that they had tried to quit, more than a third (38.6%. 39 of 101) stated that they had never tried to quit smoking (Figure 11).

Figure 11: Attempts to quit amongst smokers

	Number of respondents	Percentage
Quit attempted	62	61.4%
No attempt to quit	39	38.6%
	101	100%

Of those who reported having attempted to quit, 19.4% (12 of 62) stated that they were currently trying to stop and another 46.8% (29 of 62) reported having made a quit attempt within the last year.

Unfortunately, from the information collected, it was not possible to determine whether the quit attempts made by any of the respondents were successful.

4.4.2.4 Smoking prevalence, by managing organisation

The following results exclude 13 (8.2%) respondents where their management organisation is unknown.

Figure 12 below provides a breakdown of the smoking behaviour of respondents by organisation. It can be seen that, across all organisations, smokers are in the majority with by far the highest proportion coming under the management of the Youth Offending Service. This is significant because these offenders will all be aged between 10 and 17 years and therefore subject to the increased risks highlighted in Section 4.4.1.3 above.

Figure 12: Breakdown of smokers, by organisation

Respondents	YOS	NPS	CRC	Total
No. respondents	10	45	91	146
No. non-smokers	1	20	33	54
No. smokers	9	25	58	92
% Smokers	**90.0%**	**55.6%**	**63.7%**	**63.0%**

Figure 13 below provides a breakdown of smokers who reported attempting to quit by organisation.

Figure 13: Quit attempts, by organisation

Respondents	YOS	NPS	CRC	Total
No. respondents	9	25	58	92
No attempt to quit	4	14	18	36
Quit attempted	5	11	40	56
% Quit attempted	**55.6%**	**44.0%**	**69.0%**	**60.9%**

The highest proportion of respondents (69.0%, 40 of 58) who reported an attempt to quit were managed by DLNRCRC and the lowest (44.0%, 11 of 25) by NPS.

4.4.2 Fruit and Vegetable Consumption

The '5 A Day' guidelines were developed based on WHO's recommendations that consuming 400g of fruit and vegetables a day can reduce risks of chronic diseases, such as heart disease, cancer, diabetes and obesity.[54]

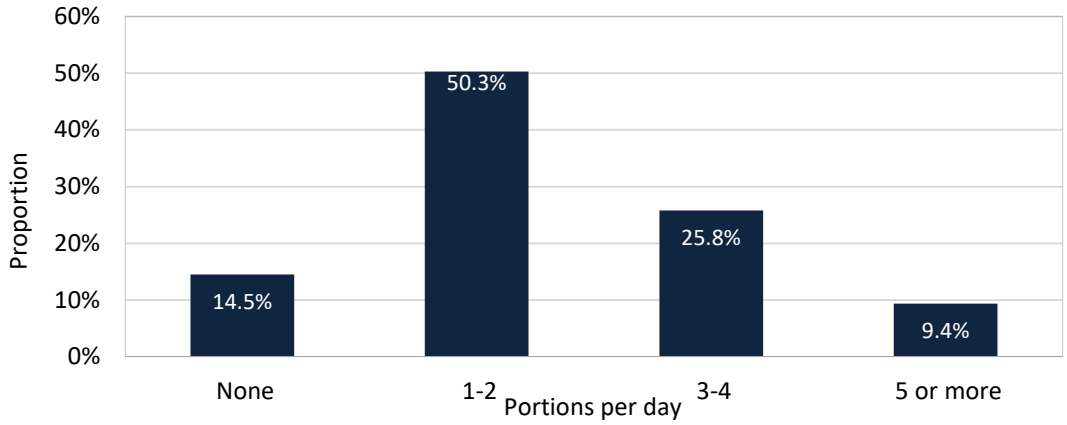
Respondents were asked how many portions of fruit or vegetables they ate in a normal day; this question was answered by 95.8% (159 of 166) of respondents.

76.1% (121 of 159) of those that responded stated that they ate between 1 and 4 portions of fruit or vegetables a day, but only 9.4% ate the recommended 5 or more. This is much lower than the 26% who reported consuming 5 or more portions in the HSE 2015.[55]

Of greater concern are the 14.5% (23 of 159) who reported consuming no fruit or vegetables daily; this is more than double the 7% reported by the Health Survey for England 2015.[55]

Responses did not differ significantly between respondents living in Derby City and Derbyshire County.

Figure 14: Portions of fruit and vegetable consumed



4.4.3 Physical Activity

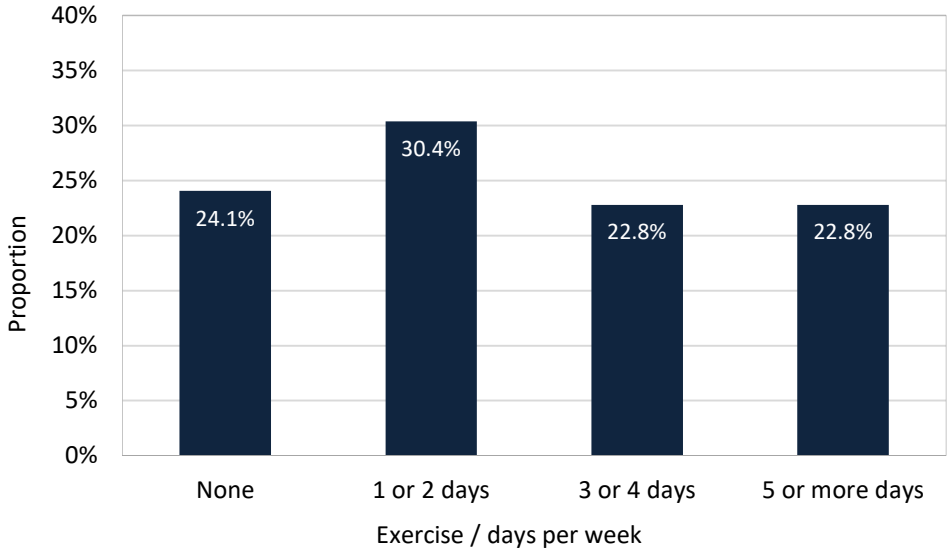
Physical inactivity is associated with many chronic conditions, including ischaemic heart disease, diabetes, osteoporosis as well as excess weight gain.[56] There is also evidence to suggest that involvement in regular exercise can provide a number of psychological benefits such as alleviating depression.[57]

In this survey, 95.2% (158 of 166) of respondents provided information about the number of days per week that they did 30 minutes of exercise sufficient to make them short of breath.

Regular exercise on 5 or more days of the week was reported by 22.8% (36 of 158) of respondents (Figure 15); this is lower than the national average of 65% reported in the 2011 Census.[58] However, the proportion who reported that they did not achieve 30 minutes exercise on any days of the week was similar to the 22% reported nationally.[59]

Responses did not differ significantly between respondents living in Derby City and Derbyshire County.

Figure 15: Physical activity participation

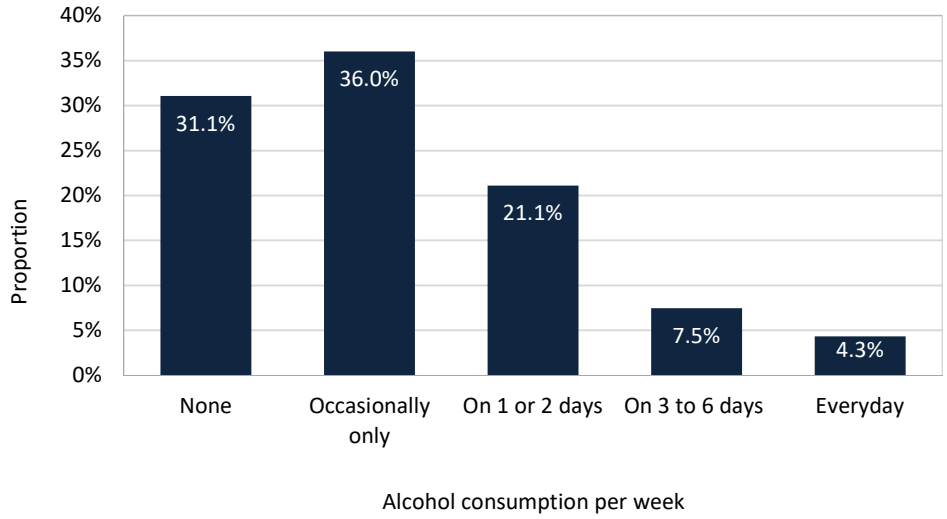


4.4.4 Alcohol

Respondents were asked about their alcohol consumption; 97.0% (161 of 166) of the cohort provided a response.

68.9% (111 of 161) of respondents stated that they consumed alcohol; their stated levels of consumption are shown in Figure 16 below. Of the remainder who stated they abstain from drinking alcohol, 13 also reported they were currently receiving help to reduce their alcohol consumption.

Figure 16: Frequency of alcohol consumption



It was noted that 11 respondents who stated that they did not drink alcohol also reported a level of alcohol consumption; for 8 this was 1-2 drinks and for 3 it was 3-5 drinks. It is possible this reflects known problems with the under reporting of alcohol consumption in surveys.[60]

Of those who reported consuming alcohol, 74.5% (120 of 161) respondents provided information on the number of drinks containing alcohol that they consumed on the days that they drank. The results for this cohort of 120 are shown in Figure 17 below.

Figure 17: Alcohol consumption, by frequency of drinking

Number of drinks containing alcohol consumed	Frequency of alcohol consumption										Total	
	I don't drink alcohol		I only drink alcohol occasionally		1 or 2 days a week		3 to 6 days a week		Everyday			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1-2 drinks	8	6.7%	26	21.7%	7	5.8%	4	3.3%	1	0.8%	46	38.3%
3-5 drinks	3	2.5%	12	10.0%	15	12.5%	8	6.7%	5	4.2%	43	35.8%
6-9 drinks		0.0%	9	7.5%	4	3.3%		0.0%	1	0.8%	14	11.7%
10 or more drinks		0.0%	9	7.5%	8	6.7%		0.0%		0.0%	17	14.2%

This survey captured information about alcohol consumption by asking about the number of drinks containing alcohol consumed per day and the frequency of drinking per week. No information from which to gauge the strength of alcohol consumed was collected. This makes finding a direct comparison for alcohol consumption in the general population a challenge, since most sources report consumptions in units per day or week.

For survey respondents, conservative estimates for alcohol consumption have therefore been calculated by assuming that one drink contains 1.5 units of alcohol and applying this to obtain

upper and lower levels of alcohol consumption per week for respondents; the results are shown in Figure 18 below.

Figure 18: Estimates for units of alcohole consumed per week

Frequency	Drinks per week	Number of respondents	Estimate units per week	
			Lower	Upper
I only drink alcohol occasionally	1-2	26	2	3
	3-5	12	5	8
	6-9	9	9	14
	10 or more	9	15	15
1 or 2 days a week	1-2	7	2	6
	3-5	15	5	15
	6-9	4	9	27
	10 or more	8	15	30
3 to 6 days a week	1-2	4	5	18
	3-5	8	14	45
Everyday	1-2	1	11	21
	3-5	5	32	53
	6-9	1	63	95
		109		

The latest alcohol guidelines from the Chief Medical Officer (2016) both men and women state that:

- Men and women should not regularly (defined as most weeks) drink more than 14 units a week to keep health risks from alcohol to a low level.
- Men and women who regularly drink up to this amount are advised to spread their drinking over three or more days per week and avoid binge drinking.
- If large amounts of alcohol are consumed on one or two occasions per week, the risks of death from long term illness and from accidents and injuries are increased.

Consuming up to 14 units of alcohol per week is considered to be 'low risk', but drinking above this level is regarded as at 'increased risk'. The more alcohol consumed above the 14 unit threshold, the higher the risk.

Applying these guidelines to the estimated alcohol consumption of respondents suggests that, if the lower limits of the estimates are accepted, 78.0% (85 of 109) of respondents are

drinking at low risk levels, but if the upper limits of the estimate are applied this proportion falls to 49.5% (54 of 109). It is therefore possible that up to 50.5% (55 of 109) are at increased risk from their levels of alcohol consumption.

It should also be noted that the cohort includes 32 (33.0%) individuals for whom the reported pattern of alcohol consumption strongly suggests that they are binge drinking and consuming between 15 and 30 units on each occasion. The cohort also includes 6 individuals ((5.5%) whose alcohol consumption may be over 50 units per week, putting them at very high risk of the sequelae of alcohol misuse.

It is important to note that whilst low risk guidelines are the same for men and women, drinking at a higher level more quickly causes severe health problem in women. It is also worth noting that alcohol consumption is known to be under reported is surveys but no attempt has been made here to weight responses.[61,62].

Research has shown that heavy drinkers not only have an increased risk of long term physical health problems and a higher risk of injury, but also have poorer levels of mental health than their low risk or non-drinking counterparts. Alcohol misuse often co-exists with common mental disorders (CMDs), such as depression and anxiety, as well as with misuse of other substances. This is clearly reflected in the responses to the questions on general health status and mental health covered in Sections 4.5 and 4.6 below.

4.4.4.1 Motivation to tackle alcohol misuse

Respondents were asked whether they had ever sought help to reduce their drinking. 93.2% (150 of 161) of those that provided information about their alcohol consumption responded; 24.7% (36 of 150) stated that they were either currently receiving help, or had previously requested help, to reduce their consumption.

Figure 19 below shows the interest in reducing alcohol consumption, by detailing the request for support by their frequency of drinking.

Figure 19: Interest in reducing alcohol consumption

Last ask for help to reduce alcohol consumption	Frequency of alcohol consumption										Total	
	I don't drink alcohol		I only drink alcohol occasionally		1 or 2 days a week		3 to 6 days a week		Everyday			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Currently receiving help	6	16.7%	3	8.3%	3	8.3%	0	0.0%	1	2.8%	13	36.1%
Within the last month	1	2.8%	0	0.0%	0	0.0%	1	2.8%	1	2.8%	3	8.3%
Within the last year	0	0.0%	1	2.8%	4	11.1%	2	5.6%	1	2.8%	8	22.2%
More than a year ago	4	11.1%	5	13.9%	2	5.6%	0	0.0%	1	2.8%	12	33.3%

In this cohort, 11 respondents reported not drinking alcohol but also stated that they were currently receiving, or had previously received help. It is possible that these individuals were reporting their current status as non-drinkers but also revealing their previous intake; this may be an indication that the alcohol interventions they received were effective.

Amongst the survey cohort, 10 individuals were subject to an Alcohol Treatment as part of a Community Order; 6 of these stated that they did not drink alcohol.

4.4.5 Substance misuse

Respondents were questioned about whether they had ever used illegal drugs and if so, how recently; 10 people did not respond to this question.

Of those that responded, 63.5% (99 of 156) stated that they had used illegal drugs, compared to 36.5% (57 of 156) who stated that they had never used drugs.

Cannabis was by far the most commonly used drug reported by respondents, followed by cocaine and amphetamines.

Figure 20: Illegal substances used by respondents

Substance	Number of respondents	Percentage
Cannabis	78	78.8%
Cocaine	55	55.6%
Amphetamine	38	38.4%
Ecstasy	33	33.3%
Heroin	25	25.3%
LSD	22	22.2%
Magic Mushrooms	22	22.2%
Crack	20	20.2%
Solvents / gas / aerosols	13	13.1%
Novel psychoactive substances	13	13.1%
Other drugs	6	6.1%

Respondents were also asked about how recently they had taken each drug they specified. This information is shown in Figure 21 below, together with the proportion of respondents who reported using each of the drugs within the given time period, expressed as a proportion of the cohort who stated that they were users of each specific drug.

Figure 21: Frequency of substance misuse

	Drug																			
	Cannabis		Cocaine		Amphetamines		Ecstacy		Heroin		Crack		Magic mushrooms		LSD		Novel psychoactive substances		Solvents / gas / aerosols		Other drugs	
Last used:	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Within the last week	29	37.2%	4	7.3%	4	10.5%	2	6.1%	6	24.0%	4	20.0%	1	4.5%	1	4.8%	2	15.4%	1	7.7%	1	11.1%
Within the last month	8	10.3%	7	12.7%	2	5.3%	6	18.2%	2	8.0%	2	10.0%	1	4.5%	1	4.8%	0	0.0%	0	0.0%	0	0.0%
Within the last year	11	14.1%	14	25.5%	4	10.5%	3	9.1%	7	28.0%	6	30.0%	3	13.6%	1	4.8%	2	15.4%	3	23.1%	2	22.2%
Over a year ago	30	38.5%	30	54.5%	28	73.7%	22	66.7%	10	40.0%	8	40.0%	17	77.3%	18	85.7%	9	69.2%	9	69.2%	6	66.7%

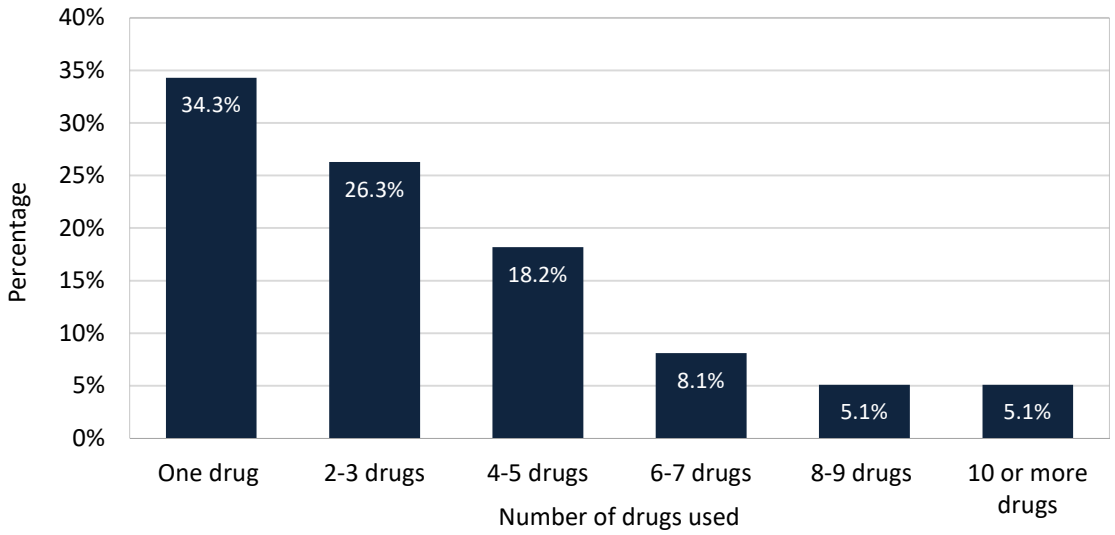
Of those that said they used illegal drugs, 44.4% (44 of 99) stated they had taken the drug specified within the last month; two thirds (63.6%, 63 of 99) stated that they had taken drugs within the last year.

Almost half of those who reported using cannabis reported using within the last month. Almost a third of respondents who were users of heroin reported having used the drug within the last month.

The majority of respondents reported multi-drug use, with nearly 1 in 5 reporting 6 or more different substances.

Figure 22 below shows the number of illegal substances used by respondents, together with the frequency that the group reported multiple use.

Figure 22: Multiple drug misuse



Respondents were asked whether they had asked for help to stop using drugs. Of those who stated that they used illegal substances, 37.4% (37 of 99) reported that they had asked for

help to stop. 13.1% (13 of 99) were currently receiving help, 9.1% (9 of 99) had received help within the last year and a further 13.1% (13 of 99) had received help more than a year ago.

In this cohort, 5 people were subject to a drug rehabilitation requirement as part of a Community Order.

4.5 General Health

4.5.1 Health Status

Respondents were asked to rate their general heath on a scale of “Excellent” to “Poor”; 3 respondents did not provide a response.

Of those that responded, 71.2% (116 of 163) of respondents rated their general health status as good to excellent, slightly below the Derbyshire average of 81% reported by the 2011 Census.[58] 6.1% (10 of 163) respondents rated their health status as poor.

Figure 23: Health status

Information about location of residence was available for 92.6% (151 of 163) of those who responded with information about their health status, enabling this information to be broken down by area.

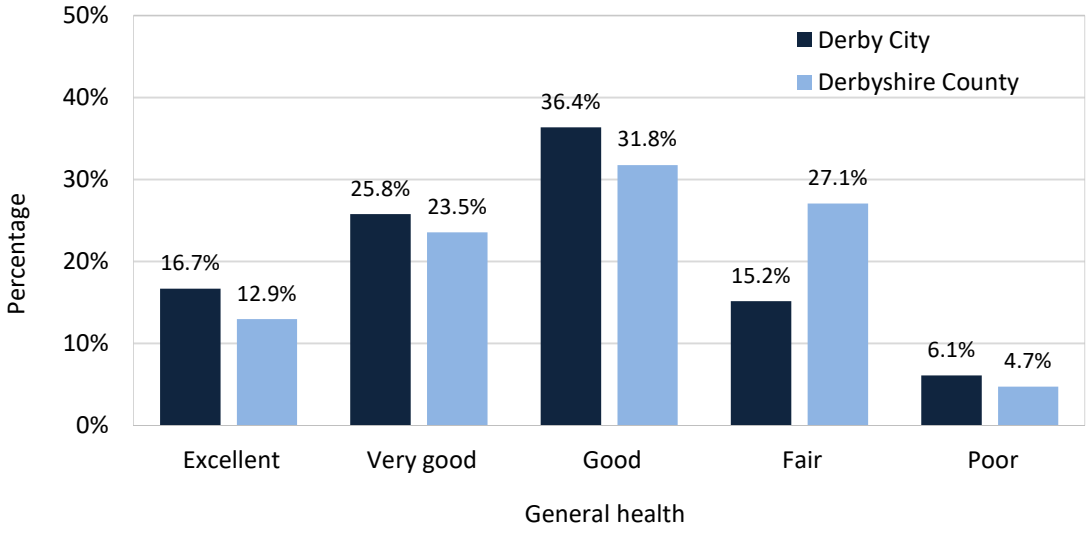
The proportion of respondents resident in Derbyshire County who rated their general health status as good to excellent was 68.2% (58 of 85); this is lower than the 79% reported for the County population in the 2011 Census.[59]

The proportion of Derby City's offenders who rated their general health status as good to excellent was 78.8% (52 of 66); although this is slightly lower than the 80% recorded for the City population in the 2011 Census, it is higher than the proportion reported by Derbyshire County's respondents.

15.2% (10 of 66) of community offenders resident in Derby City rated their health as fair, closely similar to 14% reported for the City's general population in the 2011 Census.[58] In contrast, 27.1% (23 of 85) of community offenders resident in Derbyshire County rated their health as fair, which is higher than the 15% reported for the County's general population in the 2011 Census.[58]

The proportion of Derbyshire County's community offenders who rate their general health status as poor was 4.7% (4 of 85); compared to 6.1% (4 of 66) in Derby City.

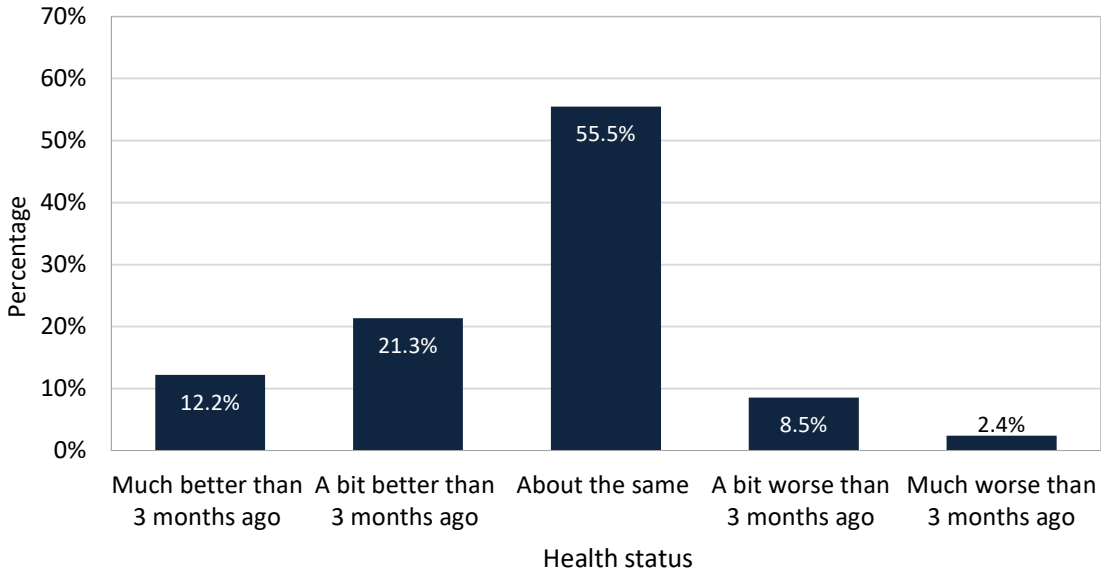
Figure 24: Health status, by geography



Respondents were also asked to compare their current health status to their status three months previously (Figure 25).

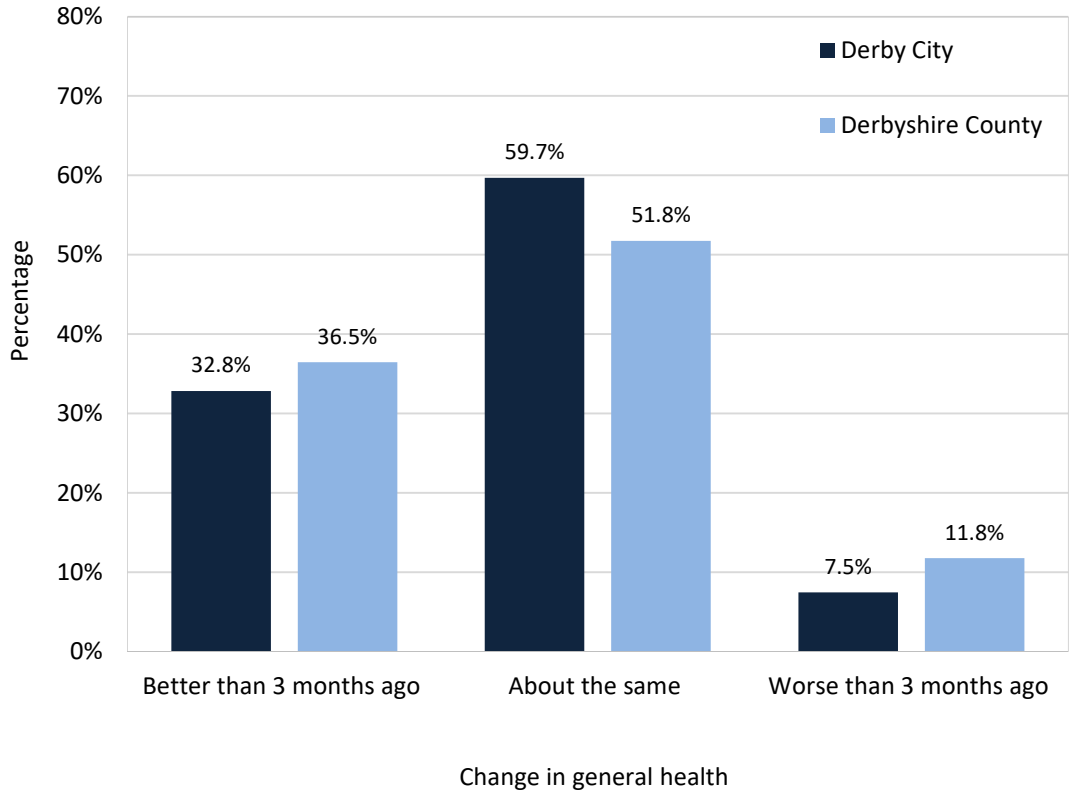
Of those that responded, 55.8% (91 of 163) reported their health unchanged over this period. 33.1% (54 of 164) reported that their health had improved but 11.0% (18 of 164) felt that their health had deteriorated.

Figure 25: Changes in health status over the three months preceding the survey



Information about location of residence was available for 93.3% (153 of 163) of these respondents, enabling this information to also be broken down by area. Here however, because of the very small numbers reporting deteriorating health, the data have been aggregated into three categories for clarity, as shown below in Figure 26.

Figure 26: Changes in health status, by geography



It can be seen that the proportion of respondents resident in Derby City who reported their health to be about the same as it had been three months previously is slightly higher than it was for the proportion resident in Derbyshire County. However, no statistically significant differences were detected when any of the results for Derby City were compared to those for Derbyshire County.

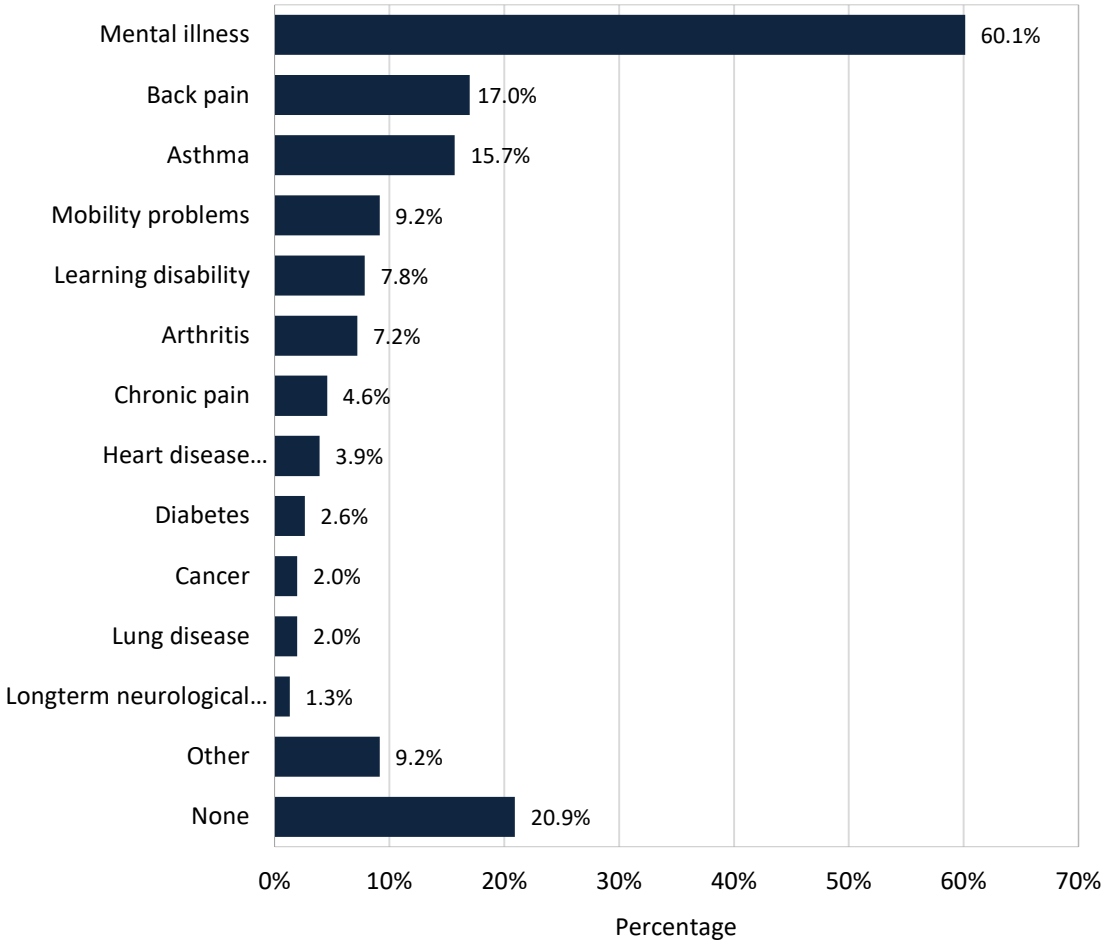
4.5.2 Health problems experienced by offenders

Further details about the health of local offenders was sought by asking respondents to specify their health problems. 92.2% (153 of 166) of the cohort provided a response to this question.

79.1% (121 of 153) of respondents specified one or more health related problems; 20.9% (32 of 153) reported that they did not have any health related problems. Where respondents reported multiple mental health conditions, these have been counted as one condition for the purposes of this question; more analysis of the information provided by respondents on multimorbidity related to mental health alone is included in Section 4.5.

Figure 27 below shows the health problems reported by offenders, together with the proportion of respondents that specified each.

Figure 27: Health problems experienced by offenders, by frequency



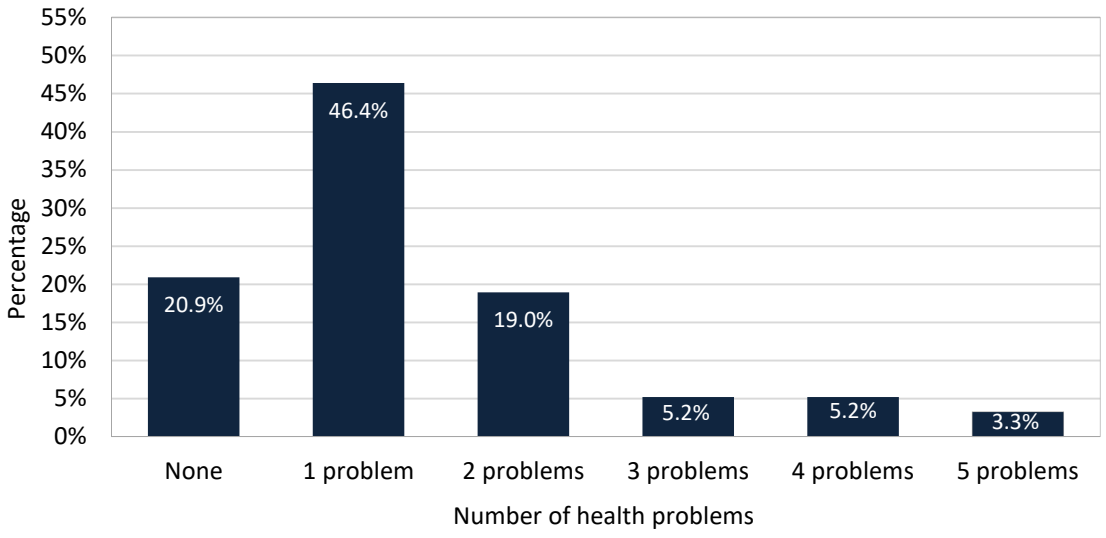
Mental health problems were by far the most frequently reported health problems amongst respondents, with 60.1% (92 of 153) reporting one or more mental health conditions. 98.9% (91 of 92) of these reported having at least one co-existing physical health related condition. Where multiple mental health conditions have been specified by a respondent, these have been counted as one condition for the purposes of this analysis. Multimorbidity in relation to mental health conditions is discussed in Section 4.6 below.

Other key findings are:

- Back pain and asthma were the next two most common conditions, reported by 17.0% (26 of 153) and 15.7% (24 of 153) respondents respectively.
- 25.5% (39 of 153) of respondents listed at least one condition related to back pain and/or mobility problems. Of these, 92.3% (36 of 39) listed more than one condition.
- 7.8% (12 of 153) of respondents stated that they had a learning disability; three quarters of this group specified at least one other condition.
- Arthritis was reported by 7.2% (11 of 153); all but one of these reported having multiple conditions.
- All respondents who reported having chronic pain had mobility related problems.
- 3.9% (6 of 153) of respondents stated that they have heart disease and/or raised blood pressure; all 6 also had other conditions.
- Attention deficit hyperactivity disorder (ADHD) was specified by 5.4% (5 of 92) respondents in this group.
- Diabetes was reported by 2.6% (4 of 153) of respondents; all of these also had other conditions.

Figure 28 below shows the proportion of respondents to this question who reported multiple conditions, by the number of problems experienced. It can be seen that only a fifth of the cohort reported having no health problems, whilst 46.4% reported one problem and 32.7% of respondents reported 2 or more health problems.

Figure 28: Number of health problems experienced by offenders



Multimorbidity is generally regarded as the presence of two or more chronic conditions in an individual but measuring the prevalence in a population is not straightforward.[63] However, it has been suggested that in England around 25% people have two or more long-term conditions.[74]

Analysis of the data obtained showed that 46.4% (71 of 153) of respondents specified one condition, whilst 32.7% (50 of 153) specified two or more conditions. This suggests that there is a much higher prevalence of multimorbidity amongst this cohort of community offenders than seen in the general population.

Figure 29 below shows the proportion of respondents who reported specific diagnoses who also reported having additional health related conditions.

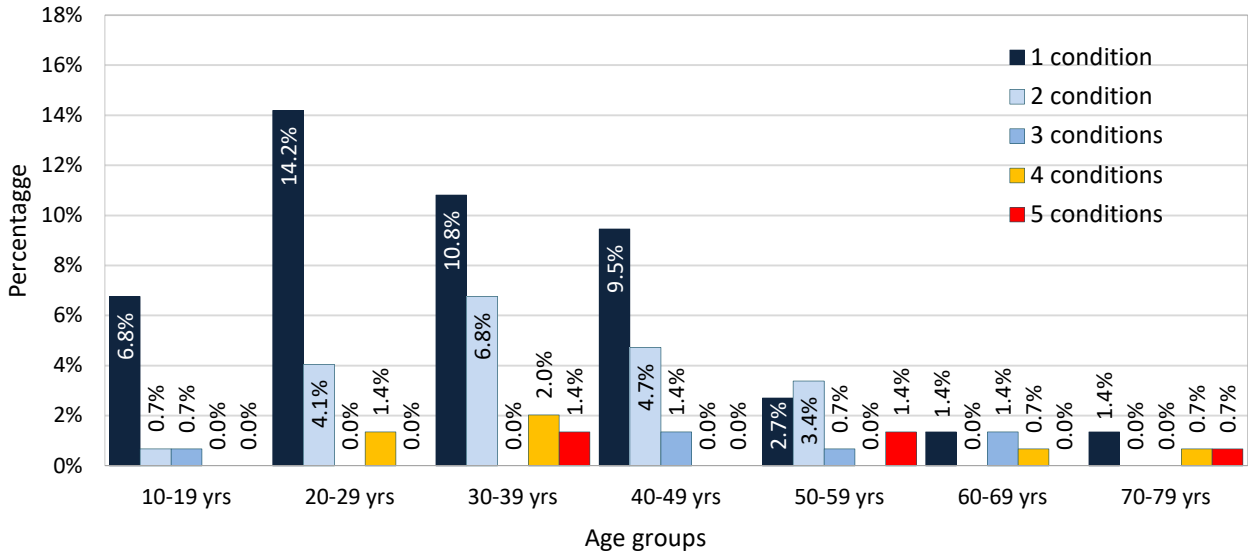
Figure 29: Survey respondents with specific conditions and multimorbidities

Health problem	Number of respondents	Respondents with multimorbidities	
		Number	Percentage
Mental illness	92	91	98.9%
Back pain	26	2	7.7%
Asthma	24	15	62.5%
Mobility problems	14	14	100%
Learning disability	12	3	25.0%
Arthritis	11	1	9.1%
Chronic pain	7	7	100%
Heart disease (including high BP)	6	6	100%
Diabetes	4	4	100%
Cancer	3	2	66.7%
Lung disease	3	3	100%
Long term neurological conditions	2	0	0.0%
Other	14	5	35.7%

Multimorbidity has been associated with a decreased quality of life, functional decline and an increase in healthcare utilisation, including emergency admissions. This is particularly seen amongst those with higher numbers of coexisting conditions.

Multimorbidity is more common in disadvantaged groups. The prevalence of multimorbidity increases with age but the absolute number of people with multimorbidity has been found to be higher in those younger than 65 years due to the age distribution of the population. This is illustrated by the distribution of multimorbidity across the age distribution of respondents who are younger overall than the general population of Derbyshire (Figure 30)

Figure 30: Survey respondents with multimorbidities, by age group



4.6 Mental health

Respondents were asked whether they had ever seen a GP or a mental health service about their mental health; 96.4% (160 of 166) respondents provided a response and 58.8% (94 of 160) reported having been seen about their mental health.

Of the group who stated that they had been seen by a GP or a mental health service about their mental health, 53.8% (86 of 160) had reported having a mental illness in response to the general health question (Figure 31 below).

Figure 31: Respondents who reported having a mental illness

General health question responses	Seen by a GP or mental health service about their mental health					
	Seen		Not seen		Total respondents	
	No.	%	No.	%	No.	%
Mental illness reported	86	53.8%	5	3.1%	91	56.9%
No mental illness reported	8	5.0%	61	38.1%	69	43.1%
Total	**94**	**58.8%**	**66**	**41.3%**	**160**	**100%**

Respondents were also asked whether they had ever been told by a doctor or mental health professional that they had any of the following mental illnesses:

- Depression
- Anxiety
- Schizophrenia
- Bipolar disorder
- Personality disorder

- Post-traumatic stress disorder
- Other mental illness

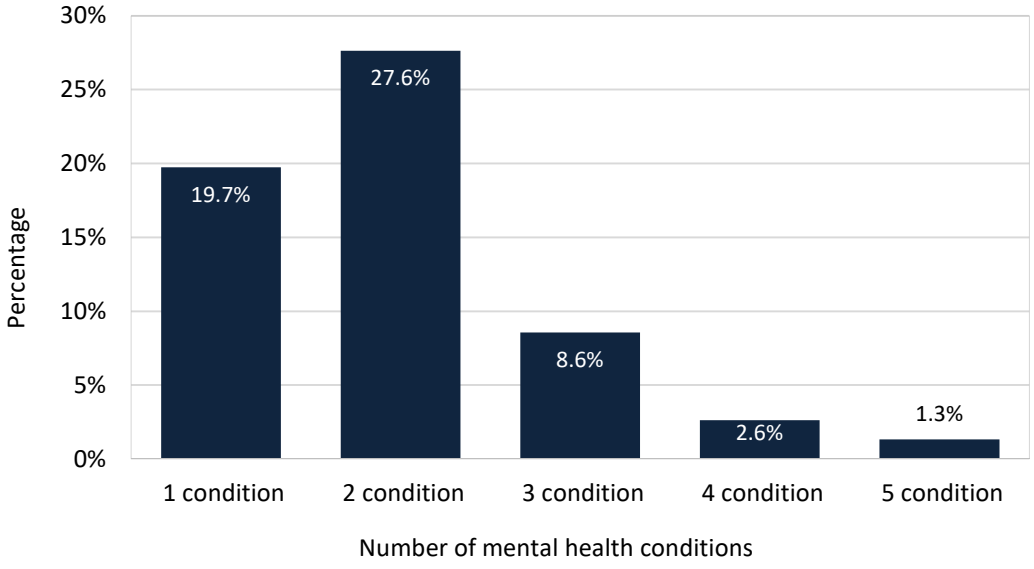
Of the group who responded to this question, 60.5% (92 of 152) reported having mental health problems; this includes 5 individuals who had had not been seen by a GP or mental health service about their mental health and 1 that did not provide details of the mental health conditions. 39.5% (60 of 152) of respondents stated that they did not have any mental illness.

Figure 32: Mental illness and contact with a GP or mental health service

Seen by a GP or mental health services	Diagnosed with a mental illness		No mental illness		Total	
	No.	%	No.	%	No.	%
Diagnosed	86	56.6%	5	3.3%	91	59.9%
Not diagnosed	5	3.3%	55	36.2%	60	39.5%
Not specified	1	0.7%	0	0.0%	1	0.7%
Total	**92**	**60.5%**	**60**	**39.5%**	**152**	**100%**

Figure 33 below shows the degree of multimorbidity experienced by respondents in relation to their mental health.

Figure 33: Multimorbidity in relation to mental health



Of those respondents who specified a mental illness:

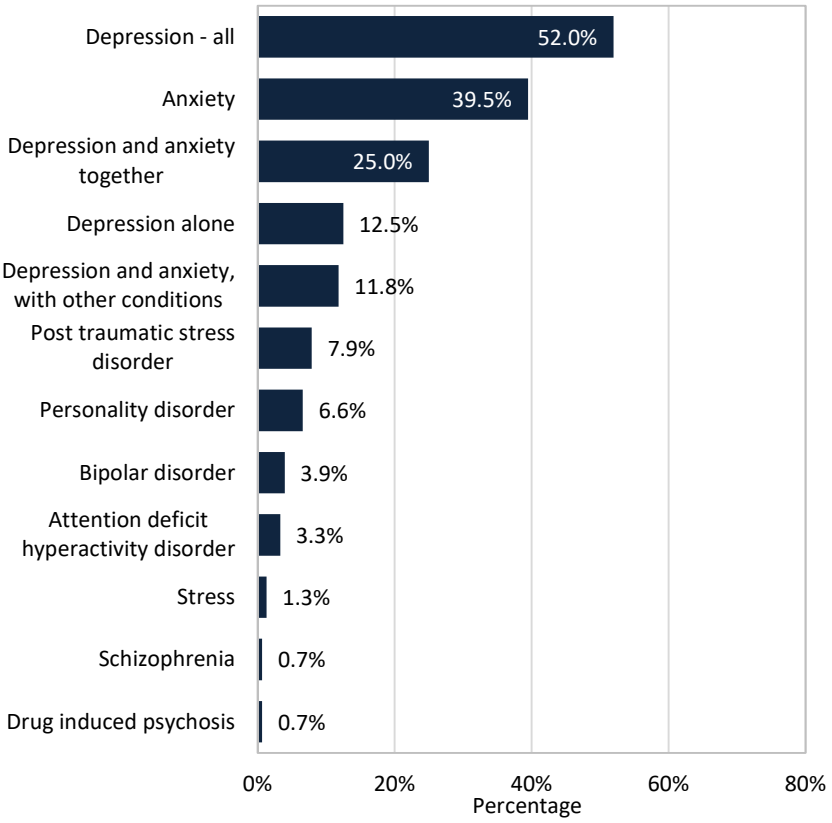
- Depression was the most common disorder specified by respondents, with 52.0% (79 of 152) of those with mental health problems reporting depression alone or in conjunction with other conditions;
- Anxiety was the second most common at 39.5% (60 of 152).
- Both depression and anxiety occurred alone or in combination with other mental conditions but were reported together by 36.8% (56 of 152) of the cohort.
- Post-traumatic stress disorder and personality disorder were the next most common conditions specified, at 7.9% (12 of 152) and 6.6% (10 of 152) respectively.

The prevalence of common mental disorders was far higher in this cohort than the prevalence reported in the general population by the Adult Psychiatric Morbidity Survey (APMS). The APMS surveyed the adult population (aged 16 and over) and found a prevalence of 5.9% for generalised anxiety and 3.3% for depressive episodes..[55,65]

Of those with a CMD in the past week, 63% were diagnosed in the past year. In the APMS, 50% with anxiety in the last week reported receiving treatment, 61% with depression in the last week reported receiving treatment, 16% with anxiety reported seeing their GP in the last 2 weeks, 23% with depression reported seeing their GP in the last 2 weeks.[65]

Figure 34 below provides a detailed breakdown of the conditions reported by this group of respondents and the frequency with which each occurred in the group.

Figure 34: Mental health conditions



Amongst the cohort who stated that they had experienced mental health problems:

- 45.7% (42 of 92) also reported other health related problems.
- 26.1% (24 of 92) of the group reported one additional condition.
- 19.6% (18 of 92) reported multiple conditions, with some respondents declaring as many as four additional conditions related to their general health.
- 67.4% (62 of 92) of those with a mental health condition also stated that they had taken one or more recreational drugs.
- 42.5% (30 of 92) had taken drugs within the last month; 25.0% (23 of 92) had taken drugs within the last year.

In this cohort, 9 people were subject to Mental Health Treatment as part of a Community Order.

4.6.1 Self harm

Respondents were asked whether they had ever thought about harming or hurting themselves and whether they had harmed themselves. 95% (158 of 166) provided a response to these questions.

Of those who responded 38.0% (60 of 158) stated that they had thought about harming or hurting themselves. Of these, 43.3% (26 of 60) confirmed that they had harmed themselves.

Respondents were also asked whether they had ever thought about killing themselves, or had tried to kill themselves. 93.4% (155 of 166) respondents provided a response. Of those who responded:

- 39.4% (61 of 155) said that they had thought about killing themselves or had tried to do so.
- Of those, 14.2% (22 of 155) stated that they had self-harmed.
- 9 individuals who admitted that they had thought about killing themselves or had tried to do so, did not self-harm and did not admit to thinking about harming themselves.
- 2 of these 9 individuals also had not reported a past history of mental health problems.

The prevalence of self-harm in the general population is not well established, since much of the behaviour may go unreported or remains hidden. Self-harm can range from skin rubbing through to suicide attempts and where research has identified a prevalence rate this is most often for a specific type of self-harm and in a subgroup of the population.

In 2016, the APMS found that 7.3% of adults surveyed in the East Midlands reported ever having self-harmed and 6.7% reported having attempted suicide; 20.6% participants reported having had suicidal thoughts.

These results suggest that the prevalence of both self-harm and attempted suicide may be higher amongst the community offenders surveyed than is found in the general population.

4.7 Infectious diseases

Respondents were asked whether they had ever had a range of infectious diseases. 94% (156 of 166) of respondents replied to this question.

- 9.6% (15 of 156) respondents reported having ever been diagnosed with an STI; 3.8% did not know their status.
- 3.6% (5 of 137) respondents reported having ever been diagnosed with Hepatitis B or C; 2.9% (4 of 137) did not know their status.
- No respondents reported having ever been diagnosed with HIV, Hepatitis A or tuberculosis.

4.8 Access to Health Care Services

Access to health care services is important to promote and maintain health, prevent and manage disease and reduce unnecessary morbidity and premature death.[66]

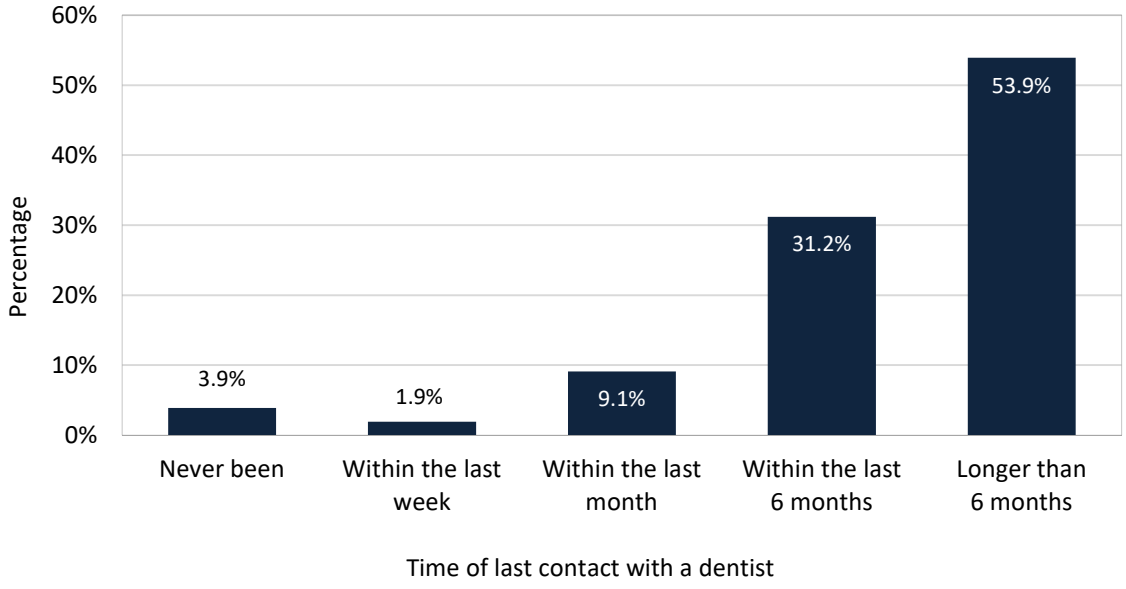
4.8.1 Access to dental services

Information about access to dental services was captured in this survey and 95.8% (159 of 166) of respondents responded.

39.6% (63 of 159) of respondents stated that they were not registered with a dentist. 53.6% (83 of 154) reported that they had not seen a dentist within the last 6 months and 3.9% (6 of 154) individuals stated that they had never seen a dentist.

Figure 35 below provides a summary of respondents contact with dental services.

Figure 35: Contact with dental services

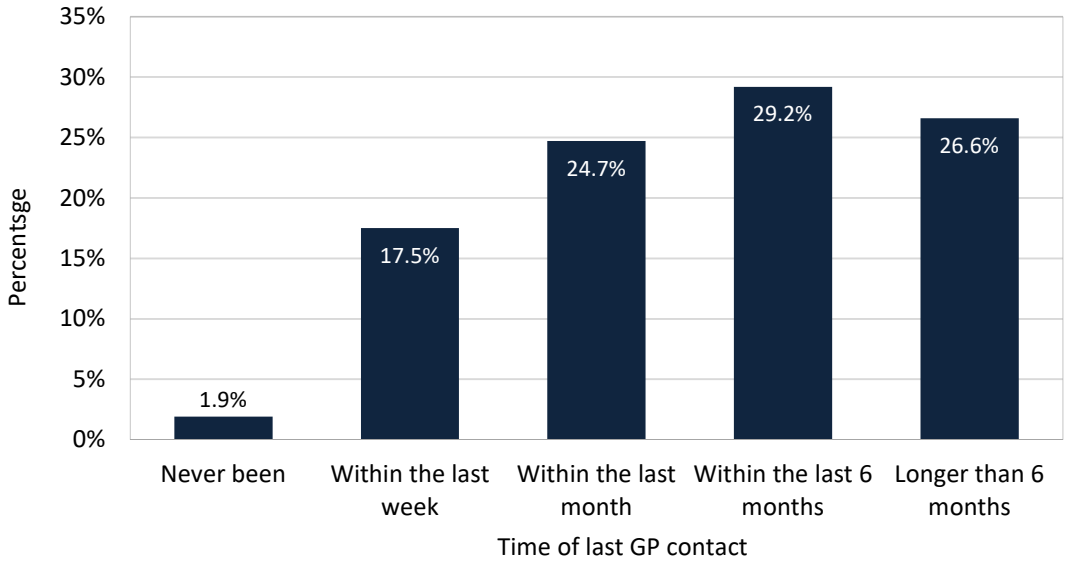


4.8.2 Access to GP Services

Respondents were asked whether they were registered with a GP practice; 3.6% (6 of 166) of respondents did not provide a response. 7.5% (12 of 160) of those that responded stated that they were not registered with a GP.

Respondents were also asked when they last visited their GP; 7.2% (12 of 166) did not respond to this question. Of those that responded 26.6% (41 of 154) reported that they had not seen their GP for 6 months or more and 1.9% (3 of 154) said they had never been seen by a GP. Figure 36 below provides a summary of respondents contact with GP services, by frequency of contact.

Figure 36: Contact with GP services



4.8.3 Access to Screening Tests

Respondents were also asked which, if any, screening tests they had received; the number who provided this information for each test is shown in Figure 37 below. With the information available, it is not possible to determine the number of respondents who met the eligibility criteria for each screening test at the time of the survey. No attempts have therefore been made to calculate the proportion of respondents screened and only key points are reported below.

- 11 respondents reported having had a bowel cancer screening test; 8 of these were known to be aged 60 years or over at time of response and 3 were between 16 and 42 years of age.
- 12 respondents reported having had a cervical screen; all were female and fell within the normal age range to be offered screening.
- 6 respondents, including one male, reported having had a breast screen; it should be acknowledged that not all were aged between 50 and 70 years.

- 46 respondents reported having had an NHS Health Check but of these, 18 were aged below 40 years and 2 did not give their age.
- 17 respondents did not know whether they were eligible for an NHS Health Check and 22 regarded the question as not applicable.

Inspection of these data revealed that, in several cases, respondents who had reported that they had attended screening were the wrong gender, or were outside the normal age range for eligibility. Whilst this is possibly accurate, given that some individuals may have received screening for clinical reasons even though they fall outside the standard eligibility criteria, it is also possible that some of these responses were made in error. As a result, these data should not be regarded as robust and should be seen as indicative only.

Figure 37: NHS screening tests

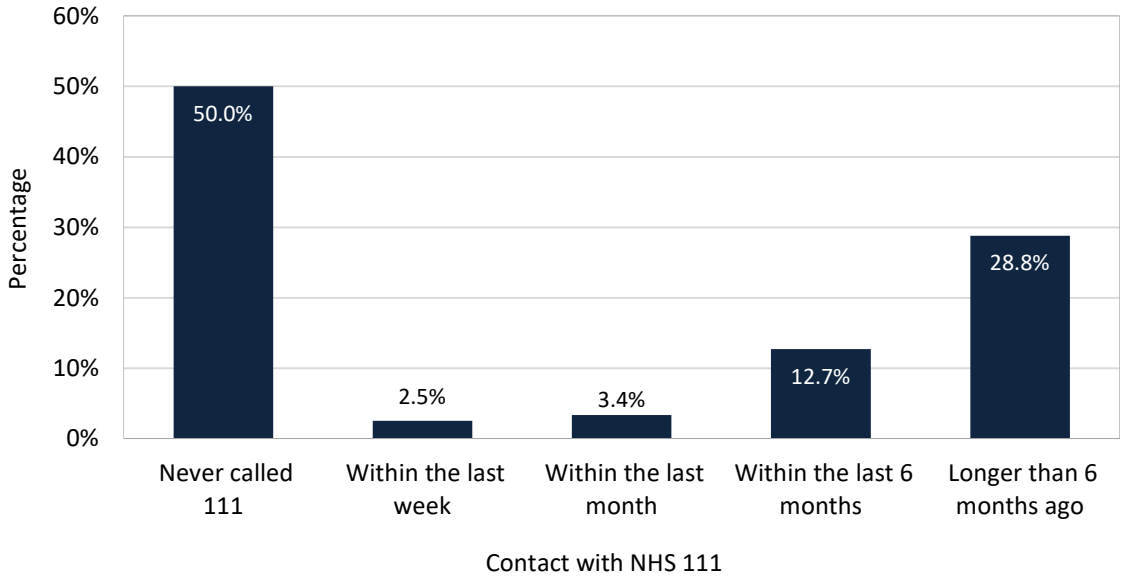
Screening programme	Number of respondents	Number			
		Screening received	No screening received	Not aware of being screened	No response
Bowel cancer	162	11	143	8	4
Cervical cancer	149	12	131	6	17
Breast cancer	151	6	139	6	15
NHS Health check	160	46	97	17	6

4.8.4 Access to urgent care services

Information was also collected about knowledge and use of out-of-hours services. Respondents were asked whether they were aware of the free NHS 111 telephone service and if so, when they last used it.

97.0% (161 of 166) provided a response. 73.3% (118 of 161) of respondents reported having heard of the service and 47.5% (56 of 118) of these said they had called the service. A breakdown of the time of their most recent call to NHS 111 is shown in Figure 38 below.

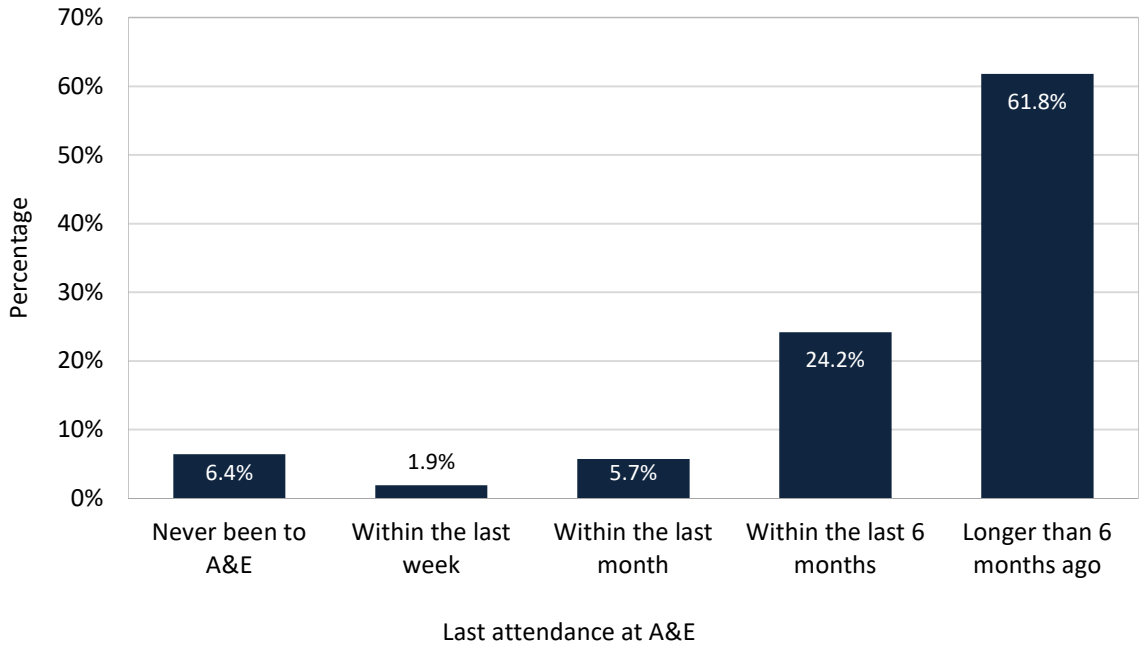
Figure 38: Time of most recent call to NHS 111



Respondents were also asked when they has last attended the Accident & Emergency (A&E) department

93.6% (147 of 157) of those who responded reported having attended A&E and almost a third of this group (31.8%, 50 of 157) had attended within the previous six months. Figure 39 below shows the time of their most recent attendance at Accident & Emergency for respondents.

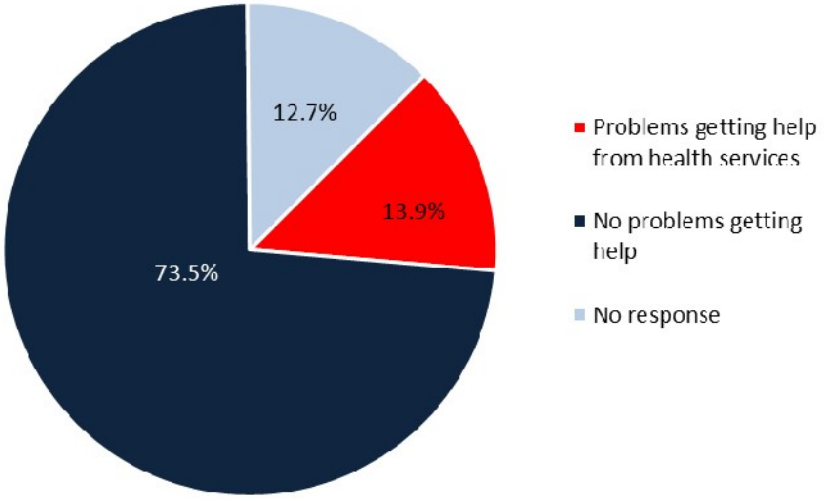
Figure 39: Time of most recent attendance at Accident & Emergency



4.8.5 Problems accessing health services

Respondents were asked whether they had had any problems in getting help from any of the health services; 86.7% (144 of 166) of the cohort responded. Of these, the majority, 74.1% (123 of 166), reported they had not experienced any problems in getting help from health services. However, 13.3% of respondents did not provide a response, therefore the summary presented in Figure 40 below may be an under-representation of the problems that community offenders face when accessing services.

Figure 40:Respondents who reported problems related to access to health services



4.9 Qualitative analysis

4.9.1 Views of offenders in the community

4.9.1.1 Background characteristics of interviewees

Nineteen interviews were completed, 13 by offenders supervised by DLNRCRC and 6 by those supervised by NPS. No interviews were undertaken by offenders supervised by YOS. The majority of interviewees were male (15 out of 19). 17 reported their ethnicity as White, and 2 as Asian/ Asian British. Respondents represented age categories from 18-19 years to 50-59 years. Interviewees were from both Derby and geographically disparate areas across Derbyshire. The majority (12 out of 19) of respondents did not report being subject to any treatment requirements. Treatment requirements reported by the other 7 respondents included other (voluntary; ATR; DRR; and mental health treatment.

4.9.2 Themes

Three themes with corresponding sub-themes were identified (Figure 41):

- Community offenders' health status;
- Access to services and
- Offenders' perceptions of health services

The remainder of this section will consider each theme in turn.

Figure 41: Overview of themes emerging from interviews with offenders in the community

	Theme 1	**Theme 2**	**Theme 3**
Main theme	Community offenders' health status	Access to health services	Offenders' perceptions of health services
Sub-themes	Self-reported health and illness	Health seeking behaviours Accessibility Release from prison	Perceptions of good practice Perceptions of bad practice

4.9.2.1 Theme 1: Community offenders' health status

4.9.2.2 Self-reported health and illness

When asked about their health status, the majority of offenders reported health problems. These included mental health problems, long-term pain, reduced mobility, sexually transmitted infections, blood borne viruses (BBVs) and ophthalmic and brain conditions. The majority (13 out of 19) interviewees considered themselves disabled and the majority (14 out of 19) perceived their health status to vary day to day.

Out of the offenders who reported health problems, those reported to cause them the most concern ranged from mental health problems (such as anxiety, panic attack and disorder), mobility problems such as arthritis, respiratory problems (including asthma), diabetes, BBVs, and substance misuse problems (including alcohol misuse).

The majority of offenders who reported health problems reported that their health affected their activities. This included preventing them from working, difficulties leaving the house, difficulties with physical activity (including carrying shopping) and walking distances, difficulties with memory loss and aggression, inability to be on time or remember things.

When questioned how their health had changed in the last 3 months, offenders provided a mixed response split between offenders stating there had been no changes to health and those who stated their health had deprecated in the last 3 months. Reasons for this included reports of worsened mental health (reported to be due to changes in benefit, inability to afford rent, lack of help and support, increased anxiety due to offence), worsened mobility and conditions such as diabetes. There was a recurrent theme that mental health and financial anxiety were intertwined.

"*My mental health has deteriorated drastically in the last 2 months. I'm on ESA* [Employment and Support Allowance] *and can't afford my rent. I am faced with homelessness and I'm scared."*

Only one offender reported to have improved health, reporting improved fitness to improve self-defence.

"Health has improved fitter, stronger from working on my appearance in case I get jumped."

4.9.2.3 Theme 2: Access to health services

4.9.2.4 Health seeking behaviours

Whilst several offenders reported there were no health problems that they would be reluctant to ask for help about, several expressed reluctance to ask for help for specific conditions. Condition offenders expressed reluctance to ask for health for included mental health problems, hepatitis C and herpes.

The reasons offenders reported stopping seeking help for conditions included fear of treatment, previous poor experience, embarrassment, not knowing where to get help and deteriorations in mental health.

"No help before. Drinking and crime. No home and embarrassing."

Several commented that their lack of use of health services was attributable to their individual lack of motivation.

"Health services are very good, it's just myself that needs to use them more and be more motivated."

Mental health services were reported difficult to access by several respondents. This was due to reasons such as not knowing *"where to go or who to ask",* as well as a long waiting list. Several offenders reported being treated badly or refused referral.

"Mental health work wouldn't refer… basically said it was just because I'm upset… and I'll get over it."

Offenders reported hospitals, dentists and GPs as being difficult to access, *"waiting up to an hour on phone to get through* [to GP], *then when you do get through there's no appointments left."*

One respondent reported that they still requires support to avoid relapse/deterioration but that it was harder to access as their mental health improved. They reported feeling that if they "*are not screaming and shouting at MH services, then it is harder to get support. Perhaps it is not deemed as urgent.*"

Offenders voiced a variety of ways in which these services could be improved. These included improving accessibility with suggestion that improved communication, more phone, better availability of help lines/numbers, answering more quickly, more funding and more staff so more appointments would all improve services. Others reported that support in the community or drop-in services would be beneficial. Respondents also mentioned that the attitudes of staff through increasing professionalism and awareness would also improve services.

4.9.3 Accessibility

To get help, offenders reported using a range of health services in the community including Midwifery, GP, Pharmacy, Dentists, Sexual health, Needle exchange, mental health services, volunteer agencies, drug and alcohol treatment and Accident & Emergency.

One offender stated they were unsure where they could access help as they were homeless.

Offenders expressed mixed opinions about whether they were able to access help for all the health problems they have. Individuals stated they were able to get help for all their health problems and were happy with the service "*I can't fault the support I've been given."* However this was not universal, with others stating they *"struggled to*

access mental health teams and services." There were several reports that people felt they were unable to get the help they needed.

Difficulty accessing health services due to insufficient appointments was a recurring theme with reports that *"obtaining a dentist is proving impossible."* The problem with waiting lists "*the mental health waiting list is horrendous"* appeared to be perceived as particularly problematic with accessing primary care services with reports that individuals were *"waiting up to an hour on phone to get through* [to the GP], *then when you do get through there's no appointments left."*

Another concern was the notion that there may be a specific threshold required to access services. One respondent reported that he still requires support to avoid relapse/deterioration but it is harder to access that support as his mental health improves. He reported that if he *"is not screaming and shouting at mental health services then it is harder to get support. Perhaps it is not deemed as urgent.*"

4.9.3.1 Release from prison

Several interviewees reported that probation services worked particularly well on release, stating probation and probation officers helped to get things sorted.

> "*Burdett Lodge* [probation hostel] *was good because they helped put things in place."*

Although some did remark that all their health needs were met on immediate release, and one did state receiving sufficient medication, a recurring comment from interviewees was that their health needs were not met on immediate release as they received either no or inadequate medication.

> "*The prison gave me a weeks worth of sertraline and these ran out before my doctor's appointment."*

4.9.3.2 Theme 3: Offenders' perceptions of health services

4.9.3.2.1 Perceptions of good practice

There were several reports of how good healthcare services had been. "*GP has been fabulous – can't fault it."* In addition, drug services were widely praised "*drug service is efficient and offers good advice and support."* Several offenders also expressed gratitude towards probation services. Several interviewees commented that they found these services helpful and supportive.

> "*Probation give me help and keep me out of prison. I don't know what I would do without them."*

Several interviewees commented the accessibility of services and helpfulness of both probation services and health care services.

> *"GP is willing to help, calls, appointments. Drug service is efficient and offers good advice and support."*

It was reported that offenders perceived services to be invaluable with reports:

> "*I don't know what I would do without them"* [probation, drug services, A&E, mental health services].

Mental health services and GP were also reported to be *"very professional, very caring and understanding. Before I wouldn't talk about my mental health but they have helped me to open up."*

Interviewees believed merits of healthcare services to be the support they provide, with several praising the helpfulness of healthcare professionals.

> *"They are very professional, very caring and understanding. Before I wouldn't talk about my mental health but they have helped me to open up."*

4.9.3.2.2 Perceptions of bad practice

Some respondents felt that the service they received from healthcare professionals was sub-optimal with a report that healthcare professionals did not provide enough information about a diagnosis and the appointment was too rushed.

Several respondents reported feeling patronised, not listened to or treated badly by healthcare services. *"Changed methadone provider from Derbyshire to South Yorkshire, due to being treated badly."* There were also numerous concerns around provision of medication with either gaps in provision or insufficient supply *"mental health medication isn't high enough have to buy additional to cope."*

Other offenders reported bad experiences with healthcare professionals, one offender reported being called a liar by doctors whilst another stated "*people laugh at me, and throw me out of A&E with no stitches and no transport."*

4.9.4 Views of the health care staff and community offender case workers

Online questionnaires were completed by 49 members of health care staff and offender case workers. A copy of the questionnaire can be found in Appendix 3. Professional respondents were able to complete their questionnaires anonymously to increase openness and honesty in responses and reduce the chance of bias in their responses.

The majority (55.1%, 27 of 49) of respondents worked for the DLNRCRC (see Figure 42). They covered geographically disparate areas across Derbyshire (see Figure 43), with a number of respondents working employed over more than one area.

Figure 42: Employment characteristics of health care staff and offender case worker

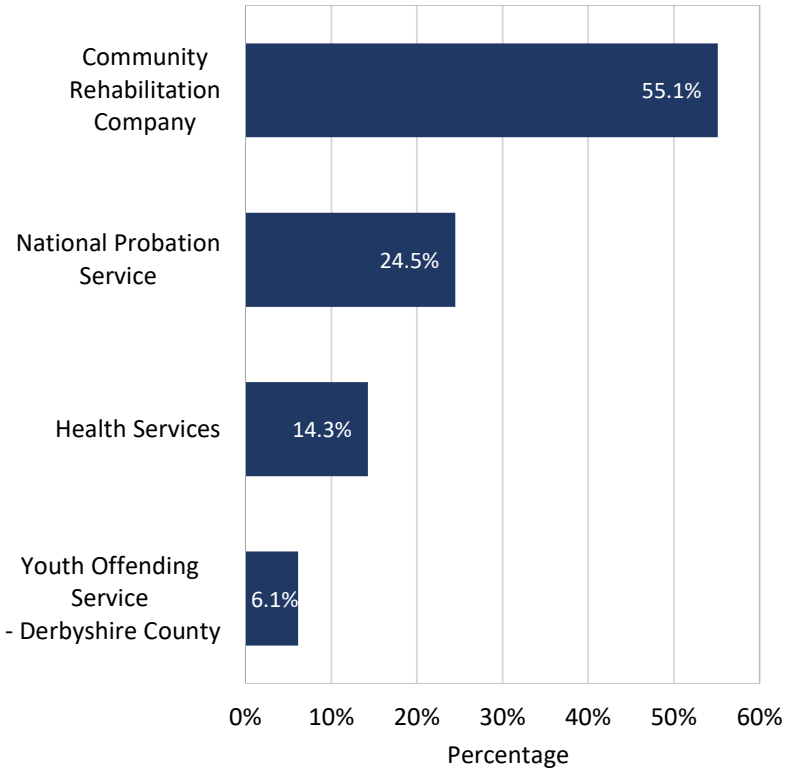
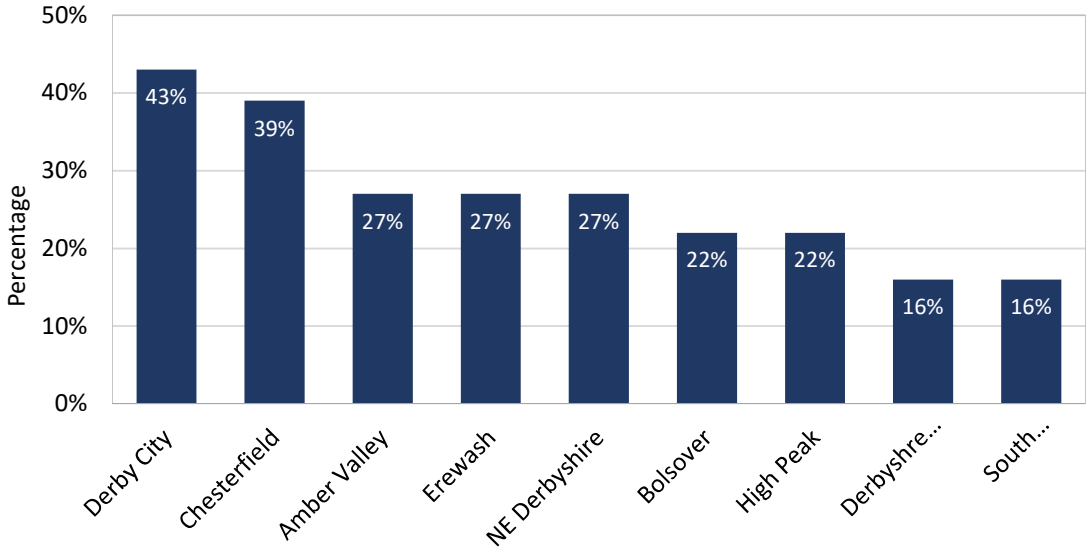


Figure 43: Areas in Derbyshire covered by health service and offender case workers



4.9.4.1 Themes from the survey of health care staff and offender case workers

The survey covered three main themes:

- Determinants of community offenders' health;
- Offenders access to health services;
- Recommendations for improvement.

The remainder of this section will consider each theme in turn (see Figure 44).

Figure 44: Overview of themes emerging from the survey of health care staff and offender case workers

	Theme 1	Theme 2	Theme 3
Main theme	Determinants of community offenders' health	Offenders access to health services	Recommendations for improvement
Sub-themes	Wider determinants of health Mental illness, lifestyle choices and confidence	Health-seeking behaviour Structure of service Service accessibility Service availability	

4.10 Findings

4.10.1 Theme 1: Determinants of offenders' health

Respondents reported a range of health issues experienced by offenders. The majority of these can be grouped into two categories: socio-economic factors and wider determinants of health (especially accommodation and financial issues), and individual characteristics such as presence of a mental illness, lifestyle choices and confidence.

4.10.2 Wider determinants of health

Financial issues were reported by many respondents as a factor reported to affect the health of offenders. In particular many respondents talked about problems with offenders receiving benefits.

"*Housing benefit claims taking a long time to process resulting in some landlords demanding the tenant pays the arrear*

Many respondents also discussed that the limited budget constrains their opportunity for healthy eating.

"With a limited budget, often only able to buy bare necessities, which is cheap, high sugared and high salted with saturated fats. They lack equipment and opportunity to cook proper healthy foods."

In addition, accommodation was frequently reported as one of the most difficult barriers for people to overcome. There was concern that access to housing and support is a prerequisite to enable help to be placed in other areas.

"Stable accommodation proves to impact the health of offenders both physically and mentally. Unsuitable accommodation can exacerbate existing health problems and also contribute toward the decline in mental health."

There were also concerns about the effect that homelessness has on both individuals and the wider society.

"*Homelessness- creates health concerns- increases mental health, exploits vulnerabilities, increased additions, increases deeper involvement in drugs and alcohol addiction, increases health issues in relation to prostitution."*

4.10.3 Mental illness, lifestyle choices and confidence

Mental health was a common concern. *"Mental health is a major issue within my caseload. Nearly all my cases have some mental health issue."*

There was reported concern about many individual characteristics and behaviours contribute to a decline in health and well-being "*drugs, alcohol, a general unhealthy lifestyle, lack of exercise, solitary lifestyles."*

Respondents discussed concern over the social confidence of offenders to make and keep appointments. Respondents remarked that community offenders may be too *"nervous to book a doctor's appointment."*

"*They* [community offenders] *have no social confidence and find it difficult to engage with surgery expectations."*

4.10.4 Theme 2: Offenders access to health services

The majority of respondents reported that offenders had difficulty accessing services. This belief was consistent across all services with the highest difficulty being mental health services (82%). The majority of respondents also reported difficulties for offenders accessing other services; sexual health services (74%), drug and alcohol services (73%), NHS Health Check programme (71%), NHS cancer screening programmes (71%), healthy lifestyle services (to stop smoking, lose weight) (62%), dentists (60%), learning disability services (56%) and GP practices (54%).

4.10.5 Health-seeking behaviour

A recurrent theme was the transient nature of the population and the fact that they move around a lot which prevents them from registering with one GP.

On questioning whether community offenders seek help for all the health problems they have, 85% of professionals perceived they did not. It was remarked that some individuals, "*simply don't know how to register* [with services]*.*" It was also suggested that although many offenders are advised to self-refer to mental health support many do not follow this up due to a lack of skills, confidence and motivation. Respondents perceived the most common issues that community offenders reported not seeking help for are mental health issues, drugs and alcohol issues and lifestyle issues.

Several respondents discussed that individuals may not perceive aspects of their health, such a dental health, to be a priority and therefore will only access treatment when in crisis.

"In addition to generally not caring about their teeth, this being the last thing for them to worry about, they cannot afford good dental care, or maybe simply unmotivated to spend what little money to have on dental care."

4.10.6 Structure of services

The majority of respondents reported a belief that offenders faced barriers accessing health services on release from prison. A recurring theme causing a barrier was the difficulty with registering with a GP and difficulty accessing a GP and sufficient medication. Another theme around the barrier of community offenders accessing services was the reported disconnect between prison and community health and the lack of appropriate referrals to correct agencies.

"Lack of joined up IT between prison and community. Prison still relies on faxes and historic issues (though improving) between drug/alcohol treatment and health provision in prison. Unplanned releases from custody hinder joint working."

To access services, many primary care providers such as GPs and dentists first require an offender to register with the service. It was reported that identification was required to register. Several respondents remarked this was prohibitive as many offenders would not have access to the necessary documents.

There was also concern around the barriers that prevent community offenders from accessing additional services without a GP referral. "*Reluctance on the part of the crisis team to accept referrals from anywhere other than a GP."*

Respondents expressed concern that the rigid primary care framework for seeing patients prevented offenders from seeking or receiving adequate and necessary healthcare.

"They are therefore easily overlooked and forgotten. In addition, when our clients present as problematic and complex, there can be a lack of readiness to fully assess their needs, as this does not fit within the five minute appointment time frame."

A recurrent theme was the detrimental effect lack of support had on individuals with mental health problems. "*They [*community offenders with mental health problems] *do not get the support they need, their lifestyle deteriorates, they commit crime."*

4.10.7 Service accessibility

Professionals reported the difficulty that community offenders may have in accessing services. Respondents stated that the lack of appointment flexibility inhibited community offenders from making or attending appointments.

"*Reasonable adjustments are not made to accommodate the needs of our clients, who are often entirely disenfranchised."*

It was also reported that those who have extreme addictions may be prohibited from accessing services with fatal consequences. *"I have been involved with people who have died as a result due to the mental health services saying that they cannot treat until addictions sorted."*

Some professionals stated they would often try to book the appointment on behalf of their client due to them lacking access to the internet/phones with credit. However they discussed the problems with being told to ring back or to wait for a call back.

"It can also be difficult because when I do call to arrange an appointment, I am informed a triage nurse will call back, and some of my cases do not have telephones/mobile phones."

There was also discussion about the lack of flexibility and strict nature of appointment times which may be prohibitive for those with very chaotic lifestyles. It was perceived

that the many services do not accommodate the chaotic lifestyle of community offenders.

"There are no real dental provision for emergencies, and then if they need a dentist, there are waiting lists to become an NHS patient that is months in advance, and by that time, the person forgets, or gets 'struck off' for not attending."

Long waiting lists following referral was repeatedly identified as a problematic factor. Several respondents discussed difficulties with referrals as these would often have to be from a GP which an offender may not attend. Several responders also discussed blurred lines between mental health requirements and substance misuse issues and that these offenders often 'slip through the net' as one service will not take ownership.

4.10.8 Service availability

It was perceived by respondents that there was a lack of commissioned services which did not meet everyone's needs resulting in a negative impact on their health and wellbeing. Additionally, insufficient appointments in primary care services were also reported to be problematic. Availability and access to services were explicitly reported as a problem for both those with minor and major conditions such as extreme addictions. Concern was voiced over specific thresholds to access services.

"A lack of services for those with Autism/ADHD who cannot access services as their condition might be minor and not reach the criteria for services."

4.10.9 Theme 3: Recommendations for improvement

Respondents believed services needed to be made easier to access for community offenders and a transient population. A recurrent theme was that services should be provided more flexibly, for example offering drop in clinics without the need to book in advance or more flexible timing of appointments. "S*ome offenders also hold down a job and are unable to attend day-time appointments as employer won't allow them time off."*

It was also suggested that to support engagement of those with chaotic lifestyles, GPs and mental health services need to be more flexible.

"Better understanding that offenders do not live a conventional life and this impact on their ability to keep to times/dates etc."

The location of services was perceived to be important and suggested that making services easier to sign post to or to find from in the 'high street' would improve access. It was stated that offender's health would be improved by health professionals going

directly to them. *"Maybe mobile centres which travel round, supporting the homeless community. Working out of homeless support shelters, libraries, police stations."*

A recurrent theme was the lack of relationship between GPs and Probation services. Professionals remarked "*it can be very difficult to get info from some GPs"*

It was perceived that the current structure of services requires offenders to self-refer to services such as mental health support and GP referral would probably help in capturing this group. It was also remarked that GPs may overlook some health needs from offenders.

"Recognition from medical services that substance misuse can be more than a lifestyle choice, it may be masking/causing real medical needs. Taking mental health issues seriously."

5.0 Discussion

This HNA has shown that the self-reported health of offenders is worse health than that of the general population; it is also clear that their health needs differ from those of the general population. The health needs of offenders are complex and multi-factorial and it is apparent that silo-ed working amongst the services providing care and support to offenders will not effectively address these needs. Improving community offenders health and access to services such as health care and resolving some of the wider determinants of health (e.g. accommodation), would help to address some of the causes of offending and also reduce the incidence of reoffending. A number of recommendations have been developed from the Health Needs Assessment, detailed in Section 6.3 below.

5.1 Strengths and Limitations

The qualitative methodology employed is deemed a strength of the HNA as it enabled development of new concepts or theories,[70] gave emphasis to first-hand experience[71] and helped determine respondents' meanings, experiences and views.[72-74] The use of flexible interviews, which encouraged respondents to describe the factors they felt were important, rather than situating the discussion within a set of pre-determined factors. The use of an interview guide ensured that the same questions were posed to each participant, establishing consistency of findings.

The HNA utilised convenience sampling to recruit respondents. While an appropriate technique to minimise resource and time intensity, potential selection bias resulting from non-probability sampling may mean that participation in the HNA may be more likely in professionals with strong feelings about the of health needs of community offenders. Professional surveys were completed by front-line staff working with offenders in the community who are at high risk of re-offending. Such individuals may not be representative of all staff working with offenders in the community and therefore limited generalisability may apply.

As the sample was not randomly selected and consisted of only a small number of respondents, caution must be exerted when using these findings to deduce inferences about the wider Derby/Derbyshire community offender population. It should be noted that no YOS community offenders were interviewed. Considering the potential selection bias alongside the relatively small sample size, the external validity of this HNA is contentious as the results may not be generalizable beyond the cohort in this HNA.[75]

Although there is a wealth of research around the health or prisoners, there is a striking lack of research relating to the health of offenders in the community.[33] It is therefore difficult to triangulate the findings from this HNA with the literature. However, the findings of this HNA echo those of the literature, suggesting that many community-based offenders have problems with accessing mainstream health services and enjoy little in the way of preventative

healthcare.[68] To complete the understanding, it would have been helpful to have some further information, such as more detail regarding conditions which would help to provide a more complete picture. Nevertheless, this research should be considered valuable as it contributes evidence to an area with a paucity of robust empirical studies on this population group. Therefore, these findings should be regarded as a step moving forwards of identifying and meeting the needs of community offenders.

The data has been analysed for Derbyshire and Derby as a whole and have not been broken down for each borough and district. Therefore it is possible that the prevalence of particular issues affecting the offender community may vary with each area.

Respondents may have had pre-conceived ideas around the impact their responses may have and therefore may have over or under-exaggerated responses. Potential responder bias should be considered. A limitation may have been the potential for community offenders to believe that their responses may impact their care, which may have caused them to under or over-exaggerate their responses. Several offenders explicitly stated requests for access to services such as “can I please get an allocated dentist.”

Furthermore, it is possible that the prevalence of health conditions reported by this HNA may represent the clinical iceberg, with many offenders not reporting or presenting them to a health professional. This is demonstrated by the underreporting of alcohol consumption in this cohort, which echoes the under declaration of alcohol consumption in the general population. Furthermore, it is possible that individuals may not have been correctly diagnosed, either due to difficulties in communication or the complexity of their multi-morbidities masking other health conditions. Therefore, it is possible that the prevalence of conditions considered by the HNA in this cohort may indeed be higher than estimated here.

Raw qualitative data was reviewed by the author only who was not involved in the interviews; it is therefore possible the omission of non-verbal dimensions of interaction such as emphasis, speed, tone of voice, timing and pauses may have allowed the author’s preconceptions room to construct meaning from the data.[76] It is possible the researcher’s preconceptions may have constructed meaning from the data, especially as non-verbal dimensions of interaction were omitted from the transcripts.

It is known that professionals and service users can often display divergent views[77] and it is therefore imperative that views of both of them are considered in conjunction. A strength of this HNA is the triangulation of offenders and professionals views with the literature.

6.0 Recommendations

6.1 Strategic development

A number of recommendations have been developed from the Health Needs Assessment. To pursue these and effectively guide their implementation there is a need to establish a clearly defined direction and control mechanisms.

- A multi-agency group with strategic responsibility for improving the health of offenders in the community, for example The Reducing Offending, Reoffending and Offender Health Board should take ownership for implementing the findings from this Health Needs Assessment.

- A task and finish group with appropriate representative should be established to take forward the recommendations.

- The findings of the Health Needs Assessment should be reported to relevant strategic groups within Derbyshire County and Derby City, including, but not limited to, Derby City and Derbyshire County HWBs, Substance Misuse Strategic Group for Derbyshire, STP Mental Health workstream board.

- Consider mechanisms for monitoring the mental and physical health needs of community offenders, which are not routinely recorded locally.

- Consider how integration of health data across organisations can be improved, particularly in relation to custody and community services.

- Map the current services to identify community offenders' need, assess how current service provision meets need and identify possible priorities for joint action.

- Consider the role of the Directors of Public Health in improving the health of this population group.

6.2 Further research

The Health Needs Assessment has highlighted a number of areas where there is a need for further research to better understand specific issues.

- Further research should be conducted to explore community offenders' experiences of primary care services to determine how this could be improved.

- Further research should be conducted to explore ways to support offenders to register with primary care services.

- Further research should explore how to empower offenders in the community and improve health literacy to enable offenders in the community to navigate services.

6.3 Care pathways

This Health Needs Assessment has identified a number of ways from which a process of best practice should be followed.

- Review the care pathway for those released from prison.
- Review access to relevant services, - particularly those surrounding wider determinants of health such as accommodation and finance services.
- Review the pathway for offenders in the community to access primary care and specialist mental health services.
- Review dual diagnosis provision to determine how services provide for those with complex needs.
- Offender's access to community lifestyle services should be assessed and improved to ensure easy access.
- Review information provided to community offenders in relation to their health, especially in relation to mental health and substance misuse.

6.4 Probation Services

All community offenders have contact with the criminal justice services (CRC, NPS, YOS). Respondents highlighted examples of positive support provided by staff in these organisations to improve their health, in particular in relation to accessing services. Several interviewees explicitly commented that probation services worked particularly well on release.

The Health Needs Assessment identified a number of recommendations applicable to the services responsible for overseeing offenders released from prison and those on community services.

- Good practice was identified in relation to the support provided by case workers, although it was not clear whether this was small numbers of staff who go above and beyond their expected responsibilities, or whether there is a consistent role for case workers to improve access to services for the individuals they support. Discussions should agree the roles and responsibilities of probation professionals to provide advocacy support to offenders accessing healthcare services.

- Case-workers should be made aware of relevant services and how to signpost offenders to them.

- It should be established whether it is within the remit of professionals to book appointments for offenders.

- Develop the relationship with primary care services to explore a more accessible method of booking appointments, e.g. by utilising their online booking.

- It should be considered how awareness of appropriate services and ways to access them can be raised amongst offenders in the community.

- Relationships should be developed between the criminal justice service and existing services for the wider determinants of health, such as accommodation, financial and healthcare services, to ensure care provided is holistic.

- Review partnership working between healthcare services and the criminal justice service and work to strengthen the relationship between professionals at these services.

- Review the community offender management structure to ensure the pathway delivers a seamless service for community offenders to transition from prison, back into the community.

- Review the working relationship between prison and community probation services to develop better partnerships, collaboration and delivery.

- Consider upskilling of probation staff, especially in relation to mental health awareness, suicide prevention and Identification and Brief Advice for alcohol use.

- Identify senior staff in NPS, CRC and YOS with a responsibility for improving health.

6.5 Service Access

The multiple and complex health needs of community offenders evidence that their health needs differ from those of the general population. This is indicative that, to access services in the same way as the general population, community offenders may require different levels of support. To protect and improve the health and wellbeing of offenders in the community, this health needs assessment has highlighted a number of areas where the involvement of healthcare services is necessary.

- Provide information to healthcare professionals on the needs of service users they identify as offenders and ensure that awareness of services available for offenders (and access routes) are understood and promoted among staff working with this group.

- To assist signposting with services: a directory of services should be developed and distributed to professionals.

- Explore how homeless people and other groups with complex needs, such as transiency, access primary care (i.e. how to register for services without any identification) and apply learning from other population groups to offenders in the community.

- Review the structure of primary care services, mental health services and services for those with multi-morbidities, in particular, means of booking an appointment and eligibility criteria to access any services.

- Consider whether health literacy, confidence and motivation of community offenders can be improved to enable them to successfully navigate the health system.

- Evaluate the use of, and impact of, mental health, alcohol or drug treatment orders within Derbyshire.

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