KENT PROBATION COMMUNITY OFFENDERS

HEALTH NEEDS ASSESSMENT 2013

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Prologue and acknowledgements

Probation Structural Changes

The Probation Service is currently undergoing significant structural change (December 2013) as part of the Government's "Reducing Reoffending" document in that a new public sector National Probation Service is being created for England and for Wales managing high risk offenders, making public protection decisions, advising the courts, providing victim liaison and managing approved premises

Every offender released from custody will receive statutory supervision and rehabilitation on release which includes legislative changes so prisoners serving custodial sentences of less than 2 years will receive at least 12 months contact made up of licence and supervision

- **There will be a nationwide 'through the prison gate' resettlement service:** they will create resettlement prisons
- **The market will be opened up to diverse range of rehabilitative providers:** There will be 21 contract package areas responsible for low/medium risk offenders and rehabilitative services. Kent is in a package area with Surrey and Sussex
- **New providers will be paid for results:** Provider's payment will be paid through a combination of 'fee for service' and 'payment by results' payment mechanisms

Kent Probation will cease to exist from 1st June 2014 and the Service will continue to maintain their service delivery up until this time. From June 2014 the organisation's work will split -services will be provided by the Kent, Surrey and Sussex Community Rehabilitation Company (CRC) or the National Probation Service (NPS). The CRC and NPS will have a revised local delivery unit structure. There will be a named senior manager link for every local authority (both upper and lower tiers).

- From October 2014, the Community Rehabilitation Company contracts will be awarded to new providers.
- While there may be new providers of probation services in the future - partnerships will still be important to reduce re-offending, protect the public and address offender needs. Offenders and their offending needs will continue to exist after the reforms and partnerships to address these will still be important.
- Kent will be in the Community Rehabilitation Company with Kent, Surrey and Sussex

Each Community Rehabilitation Company will:

- Manage medium risk and low risk of harm cases excluding MAPPA registered cases
- Provide 'through the gate services'

- Most interventions, including Community Payback, some Accredited Programmes and Specified Activity Requirements, will be included
- Manage most Integrated Offender Management offenders
- Deliver new short sentenced prisoner supervision post release in the community

Other changes as part of the Transforming Rehabilitation programme include:

- Legislative Changes
  - Less than 12 months prison given 12 months licence and supervision
  - Less than 24 months prison given min of 12 months licence and supervision
  - There will be a new rehabilitation requirement for Community Orders (this will combine supervision and specified activity requirement)
- Prison Estate will be reconfigured to establish 'resettlement prisons' in local areas.
  Kent's and Medway's resettlement prisons are:
  - Elmley
  - Rochester
  - Blantyre House
  - Stanford Hill
- Competition of all prison resettlement interventions

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Community Offenders

Particular thanks and respect are offered to all those Community Offenders who gave willingly of their time to be interviewed and share their experiences and insights into their health needs. It was striking how enthusiastic they were to help with this research and how much they wanted to thank some services and help improve others.

This Health Needs Assessment for Kent Probation Community Offenders
was considered and adopted by the Kent and Medway Reducing Reoffending Board at its meeting on Monday 3rd March
2014

Signed ……..	Signed …….
Date ……..	Date ……..
Chief Executive **Kent Probation**	**Public Health Consultant** **Kent County Council**

Kent and Medway
Community Offenders Health Needs Assessment

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Executive Summary

Introduction

This Health Needs Assessment focuses on identifying the health needs of community offenders supervised by Kent Probation which covers both the administrative areas of Kent County Council and Medway Unitary Council The report was initially commissioned jointly by Kent Probation and the former NHS Kent and Medway through the Integrated Offender Management Partnership and is the first Kent locality integrated health needs assessment undertaken in this format and taken up by the Kent and Medway reducing Reoffending Board. It therefore serves as a reference point for future service development.

Methods

The study was carried out using the three main methods of epidemiological, corporate and comparative health needs assessment.

The epidemiological needs assessment consisted of a quantitative analysis of the results from the Community Offenders Health and Wellbeing Survey and a literature review for evidence of effectiveness.

The corporate (qualitative) needs assessment consisted of interviews with community offenders and consultation with key stakeholders within the Probation Service and healthcare providers.

The comparative needs assessment compared existing and evidenced morbidity of Kent Probation Community Offenders against other English area community offender populations, where known as well as the populations of Kent and Medway.

Results

In Kent and Medway in 2013 there were about 4303 community offenders being managed by Kent Probation at any one time. The health needs of these community offenders are by and large the same or very close to those in prison. The main difference is that prison often provides “a containing environment” where healthcare can be delivered. In the community those same health needs are engaged with poorly by the offenders themselves and the services are not responsive to those whose lifestyles are often chaotic.

Offenders have a higher level of learning disability, mental health and substance misuse problems (DH 2009)

Younger offenders are more likely to be ex care leavers, victims of abuse (Social Exclusion Unit 2003)

Social and environmental conditions such as unemployment, poor and hard to access housing, complicated benefits system and health referral systems that pose a great challenge for the majority of this cohort. (DH 2010)

They are ill equipped to manage frustration and without adequate social safety nets are vulnerable to relapse and /or re-offending.

Kent and Medway community offenders have the following health morbidity and needs:-

- At least double the Mental Health needs than the general population
- 66% with substance misuse needs
- 43% or more with alcohol misuse needs
- 20-30% with a learning disability need
- 52 - 80% with smoking cessation needs

They are a younger cohort than the general Kent and Medway population and therefore less likely to have a long term condition but they do however engage in risky lifestyle behaviour that can result in a long term condition.

They are more likely to suffer trauma and injury as a result of violence.

Around 33 - 75% of the cohort is not registered with a local GP.

Ex-offenders in the older age groups are likely to have shorter life and suffer a long term condition.

This needs assessment has found some significant areas of good practice and encouraging good work between partners particularly in a time of great transition. This health needs assessment recommends that this work continues.

Recommendations

- All services including primary care, community services, public health commissioned services and mental health services need to be proactive in engaging with this group of offenders through integrated commissioning and meeting NICE standards.
- Access to mental health services should be made simple so that community offenders easily know (a) who is their primary care MH worker and (b) how to access services
- Mental health services have to be responsive commissioning by monitoring and evaluating services to ensure that this happens.
- Offender management staff need to continue to ensure that the health needs of community offenders leaving prison are assessed, ensure that their client needs are recorded and referred onto appropriate services and that this activity is appropriately monitored by the relevant oversight organisation.
- The current good practice between Kent Probation and the commissioned Personality Disorder service should be audited and shared with commissioners and partners.
- There is currently a commissioned resource for mental health counselling which currently meets a level of demand. Consideration should be given to working with community commissioned MH counselling services e.g. MHCO to provide extra capacity and possible streamlining.
- Commission training for all front line staff in IBA for alcohol misuse.
- Current commissioned services for community offenders who are not managed on license and perceived to be at greater risk of hazardous and harmful behaviour due to not having had a prison regime, need to be proactive in providing services for this group and this should be a KPI.
- Due to a high smoking prevalence rate in this group public health commissioned services need to prioritise and target this group for smoking cessation services and harm minimisation services.
- Given the many changes to structures and personnel in the health and offender management organisations that there is a published list of organisational leads for health for everyone to access on relevant websites.
- Improve health literacy of offender management staff e.g. use of NHS Choices, Live It Well, and how to access relevant and reputable health improvement websites.
- Develop the use of the Healthy Living Pharmacy for smoking cessation for community offenders.
- PH Kent KCC and the emerging offender management organisations develop a “Healthy Probation” health improvement/promotion model utilising relevant stakeholders to drive forward community offender health improvement linked to clear outcomes with locality targets set. (Also see UK Health Promoting Prison and Healthy Returns Initiative in USA (California).
- That PH Kent KCC and the emerging offender management organisations agree a common data set relating to the physical and mental health needs of community offenders and ensure that there is regular update for relevant lead individuals and Partnerships through a Health & Wellbeing Group.
- Develop clear contact arrangements with Kent & Medway CCGs regarding offender health to enable better and more robust engagement between primary care clinicians and community offenders.

- Current data integration and data quality across partner organisations is poor and needs to be better integrated between Kent County Council, the NHS and Offender management organisations as part of Better Care/Integrated Health & Social care.

Introduction

Significant amounts of literature exist around the health of those within the prison estate and particularly the mental health of this population. (Marshall 2000; Singleton et al 1998). Whilst there have been a limited number of HNAs of community offenders in England the literate base still remains small in comparison to the custodial cohort.

Offender Care Strategies (2005) concluded that this community population would have similar needs to those of prisoners mainly around physical health, mental health and substance misuse.

In the community many offenders seem to have difficulty accessing mainstream health services and tend to overuse Accident and Emergency facilities, but have very little provision of preventative health care or health promotion. (DH 2007)

The physical and mental health care of offenders in the criminal justice system has often been subject to calls for reform. Improving outcomes for this cohort is important both in terms of reducing re-offending and successful rehabilitation. Offenders are subject to significant health inequalities and often come from local deprived communities. They are more likely to experience mental health problems or lave learning difficulties and are also more likely to have substance misuse problems around drugs and alcohol. (DH 2009)

Whilst significant progress has been made in delivering improvements in health outcomes across the population, meeting the needs of the small population of people with the most complex needs remains a considerable challenge. People from socially excluded groups experience poor health outcomes across a range of indicators including self- reported health, life expectancy and morbidity. (DH 2010)

Social exclusion is applied to individuals who are:

- Suffering multiple and enduring disadvantage.
- Cut off from the opportunities most of the population take for granted, and this applies to offenders and ex-offenders as well as people with mental health problems, substance misusing individuals with learning disabilities, long term unemployment etc.

These groups overlap and individuals often have multiple and complex needs. 67% of prisoners were unemployed in the four weeks prior to their imprisonment, compared to an unemployment rate of 5% in the general population (Social Exclusion Unit 2002). A boy whose father was in custody is 3.3 times more likely to commit a crime (Cabinet Office 2006).

Ex-offenders often face discrimination and the double disadvantage of both health inequality and difficulty of access to health services generally, and primary care in particular. Complex needs and chaotic lifestyles make it difficult for socially excluded people to access services and navigate systems. Many socially excluded people have low health aspirations, poor expectations of services, and limited opportunities to shape their care. Socially excluded people often do not appear in needs assessments, health care for socially excluded groups is of low priority and the needs of these groups tend not to be at the forefront in strategic commissioning (Cabinet Office 2006)

Mair and May (1997) found that offenders on probation reported health problems similar to that of offenders in prison, with 49% saying they currently had or expected to have a certain long term health problem or disability. Common problems were muscular skeletal, respiratory and mental health.

Context

This section provides background information on the characteristics of the Kent Probation Community Offenders population within Kent and Medway but it is helpful to put this offending population into perspective along with other offender groups in the UK.

In October 2013 there were 84,987 people in prison in the UK comprising 81,000 men and approximately 4000 women. This is just below the operational capacity of 85,828. There were also some 904 individuals in the NOMS operated Immigration Removal Centres (IRCs).

In Kent and Medway the operational capacity of the 8 prisons and the 1 IRC is 4755 with female prisoners comprising 100 at HMP East Sutton Park. This total Kent and Medway prison population makes up some 5% of the total UK prison population. HMP Canterbury closed in April 2013 and HMP Maidstone rerolled as a foreign national's prison.

Facility	**Capacity**
HMP Blantyre House	122
HMP Cookham Wood	131
Dover IRC	316
HMP East Sutton Park (due to close)	100
HMP Elmley	1252
HMP Maidstone	600
HMP Rochester	658
HMP Stanford Hill	464
HMP Swaleside	1112
Total	4755

Table 1 Prison Establishments in Kent and Medway 2012/13

All these facilities have had a comprehensive Health Needs Assessment carried out by the former Kent and Medway Primary Care Trusts and these assessments can be found at the Kent and Medway Public Health Observatory website (www.kmpho.nhs.uk).

The numbers of individuals who passed through police custody in Kent and Medway during 2011/12 numbered some 44,000 although due to the new Kent Police operational model numbers coming through custody were expected to drop by some 20%. At any one time the 7 police custody suites have an operational capacity of 168 (excluding the Longport facility). A comprehensive Health Needs Assessment was again carried out in April 2012 and it can be found at the Kent and Medway Public Health Observatory website (www.kmpho.nhs.uk).

The Kent Probation's Mission is: Changing Lives, Reducing Crime. Their published Purpose is to "Protect the public and reduce re-offending by delivering the orders of the courts and by helping offenders to reform their lives."

To achieve this Kent Probation's vision is:

- To be an excellent and efficient organisation which protects the public and achieves positive change for offenders and communities by reducing re-offending
- To develop our business proactively, in partnership with our stakeholders and driven by offender need, best value, and the priorities of local communities to become provider of choice

- To be a cohesive organisation which values, supports and develops its staff so that together we can realise our collective potential and be empowered to achieve the highest standards

This Community Offenders Health Needs Assessment supports this Vision by assessing the health need of this offender population and thereby enabling them to bring about positive change in their lifestyle.

The basic process that every offender will go through from the time of being sentenced to completing their order or licence can be found on the Kent Probation website:- www.kentprobation.org/index.

The data complied is from core Kent Probation data and covers the caseload demand in Kent and Medway, at area team level and also at locality level. The caseload analysis of offender characteristics was based upon data provided as at 31st March 2013 and as well as by location, gender and age profiles, Offender Group Reconviction Scale data (v3) have also been included.

The total number of Offenders subject to a community sentence in March 2013 was 4304 and comprises of the area team numbers in Table 2 and Chart 1 below. North Kent comprises 2 area offices Medway and Dartford & Gravesham, Central and West Kent comprises 3 area offices Maidstone, Swale and West Kent (Tunbridge Wells) and east Kent which comprises of 3 area offices Canterbury, South East Kent (Folkestone) and Thanet.

Area Team	Numbers	Percentage
North Kent	1343	31%
Central & West Kent	1345	31%
East Kent	1616	38%
Total	4304	100%

Source: Kent Probation 2013

Table 2 Number of Community Offenders by Area Team March 2013

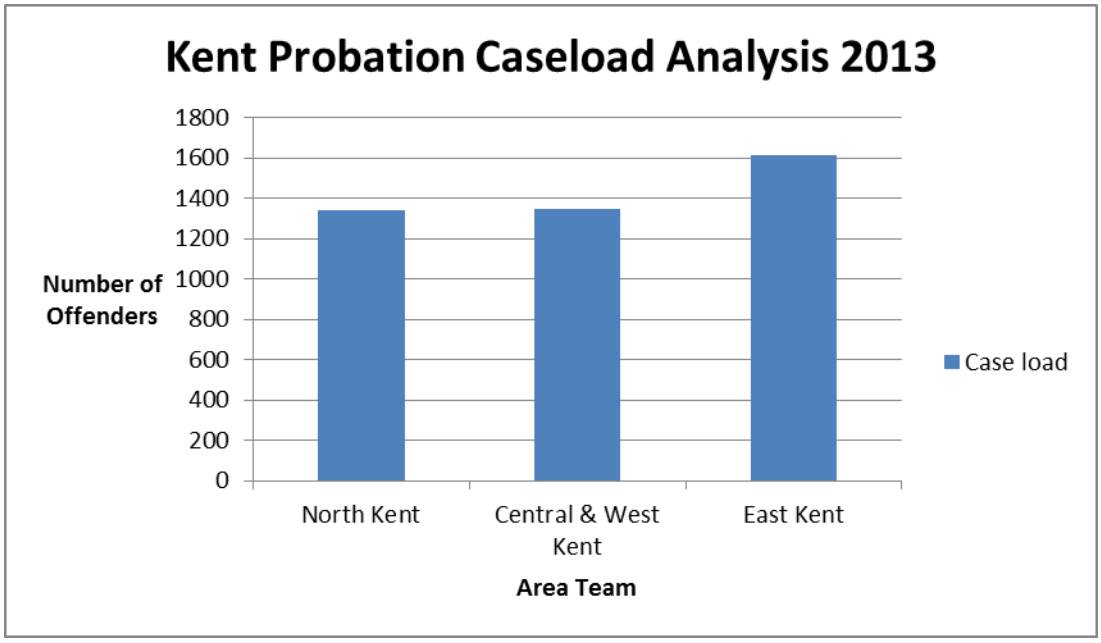


Chart 1 Number of Community Offenders by Area Team March 2013

North		**Percentage of total**
Medway	857	20.0
Dartford & Gravesham	486	11.30
Central & West		
Maidstone	468	10.8
Swale	406	10.9
West Kent	471	9.4
East Kent		
Canterbury	343	8.0
South East Kent	791	18.4
Thanet	482	11.2
	4304	100

Source: Kent Probation 2013

Table 3 Number of Community Offenders by Locality Office March 2013

Office	Community Order	Suspended Sentence	Post Release Licence	Grand Total
Medway	376	235	246	857
Dartford & Gravesham	218	119	149	486
Maidstone	236	97	135	468
West Kent	238	106	127	471
Swale	154	130	122	406
Canterbury	189	97	57	343
South East Kent	352	233	206	791
Thanet	240	117	125	482
Grand Total	2003	1134	1167	4304
Percentages	46.5	26.4	27.1	100

Source: Kent Probation 2013

Table 4 Number of Community Offenders by Locality Office and management status March 2013

Whilst the numbers of community offenders was 4304 as at the end of March 2013 Kent Probation managed some 5464 offenders in the 12 month period April 2012 to end of March 2013. This gives a “churn” rate of 1160 offenders for 2012/2013 some 27%. (Source Kent Probation OASys data)

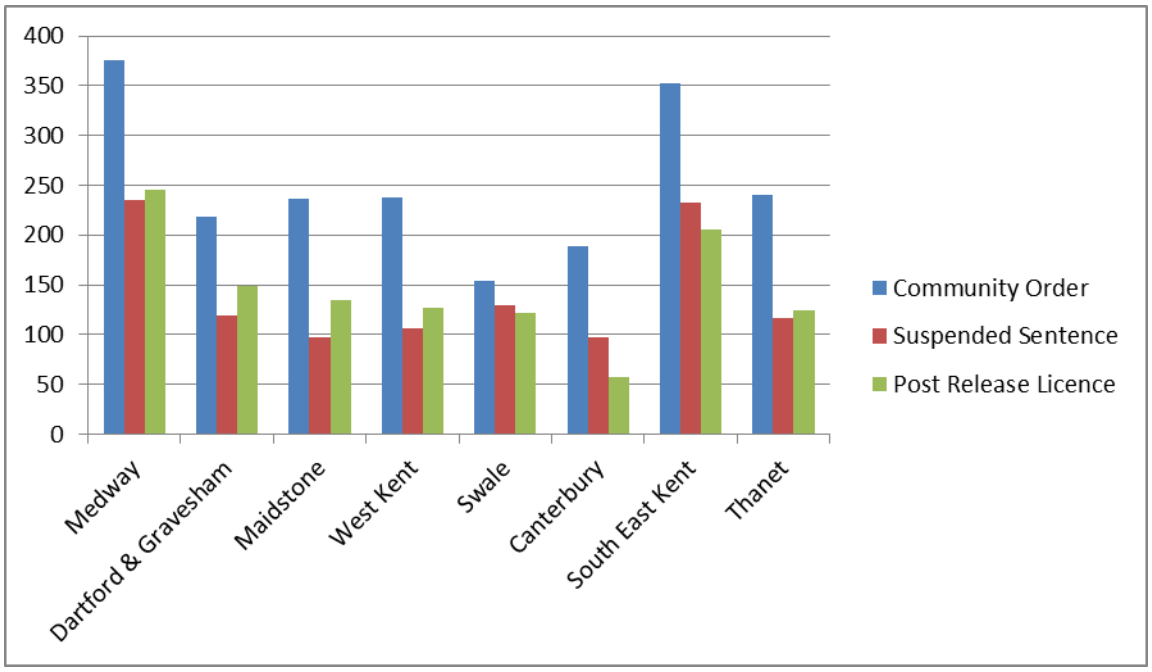


Chart 2 Number of Community Offenders by Locality Office and management status March 2013

Gender	Numbers	%
Male	3755	87.24
Female	549	12.76
	4304	100.00

Source: Kent Probation 2013

Table 5 Kent Probation Supervised Offender Gender Status March 2013

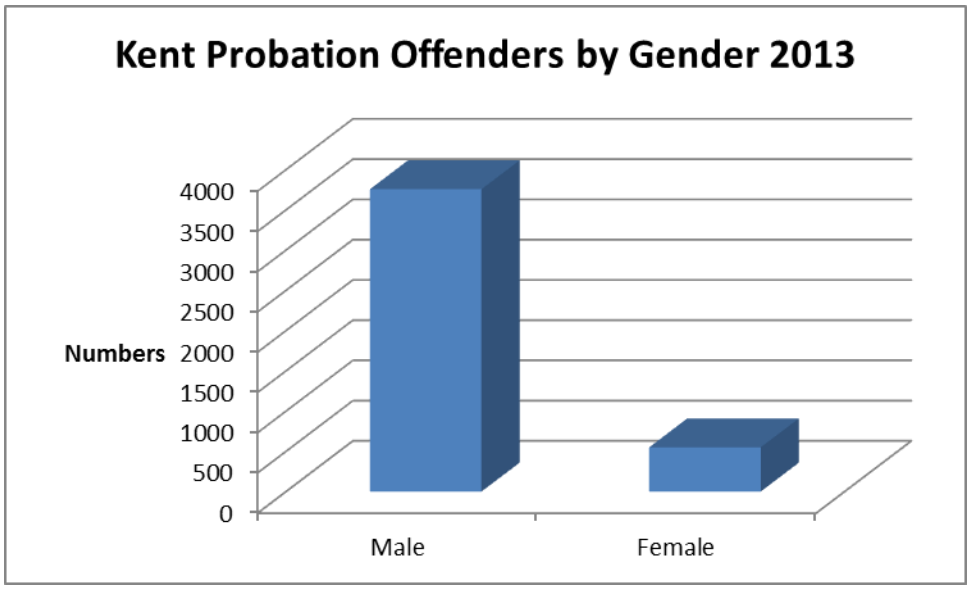


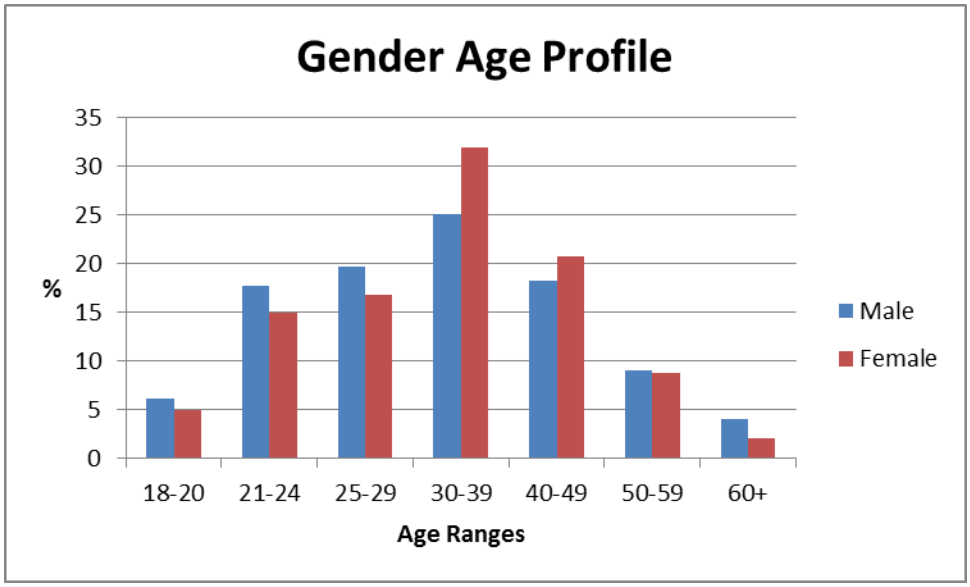
Chart 3 Kent Probation Supervised Offender Gender March 2013

Age Group	Numbers	%
18-20	258	5.99
21-24	747	17.36
25-29	832	19.33
30-39	1119	26.00
40-49	801	18.61
50-59	387	8.99
60+	160	3.72
	4304	100.00

Source: Kent Probation 2013

Table 6 Kent Probation All Community Offenders Age Ranges March 2013

The age structure of this cohort of offenders is predominately young adults when compared with the population of Kent and Medway with the Kent Probation population comprising approximately 23% under 25 years of age, 43% under 30 and 69% under 40 years of age. Those over 50 and 60 years of age comprise approximately 13% and 4 % respectively. Some 45% of this group are between the ages of 25 and 39.



(Source Kent Probation 2013)

Chart 4 **Kent Probation Gender Age Ranges Community Offenders Age Ranges March 2013**

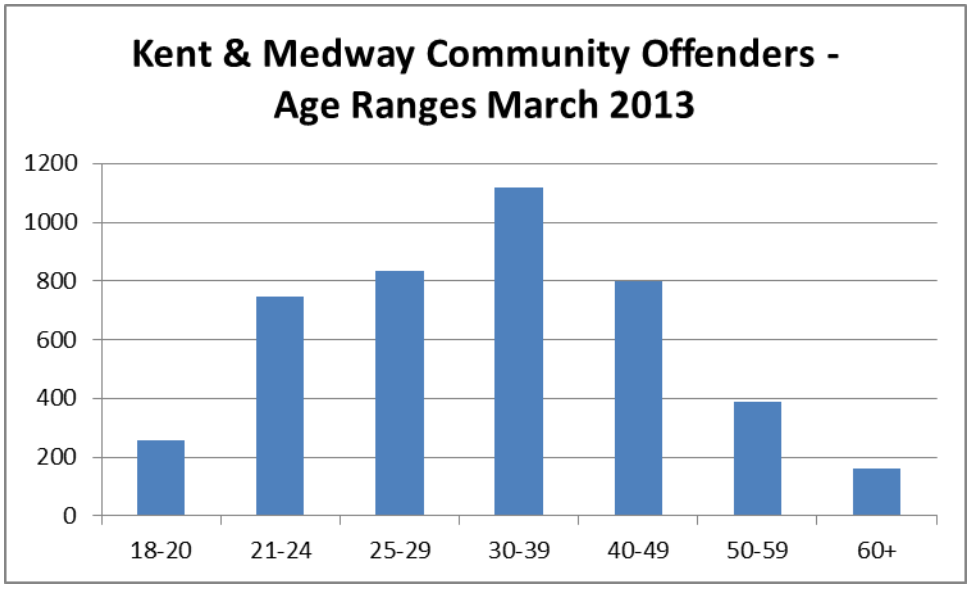


Chart 5 **Kent Probation All Community Offenders Age Ranges March 2013**

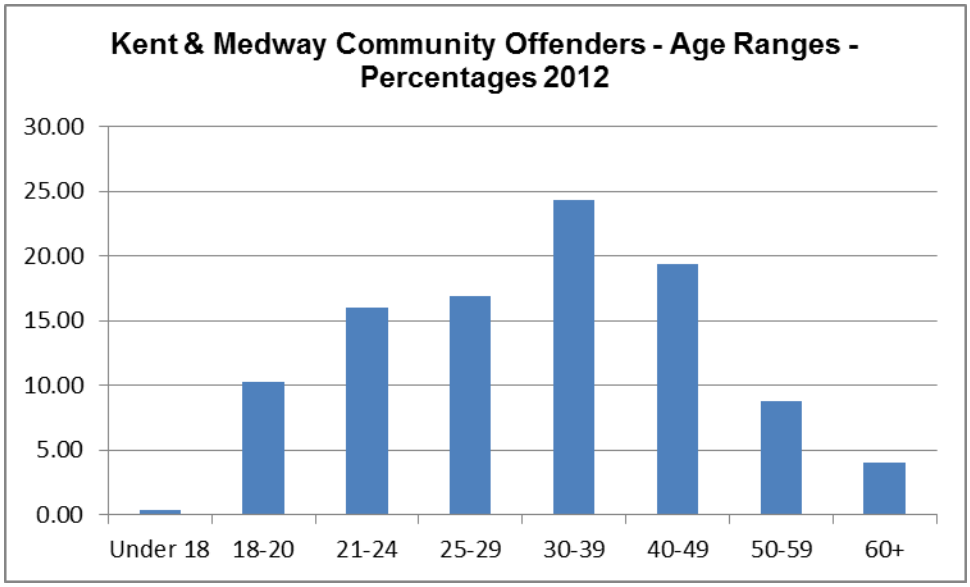


Chart 6 **Kent Probation All Community Offenders Age Rangers as percentages July 2012**

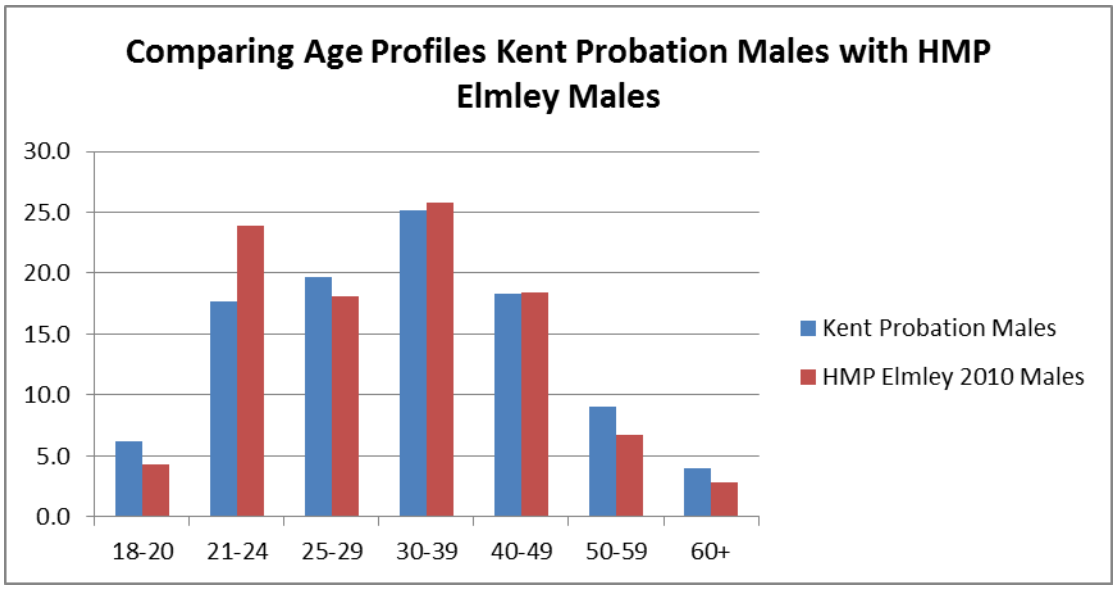


Chart 7 **Comparison of Kent Probation Male Community Offenders Age Ranges 2012 with HMP Elmley male population as percentages 2010**

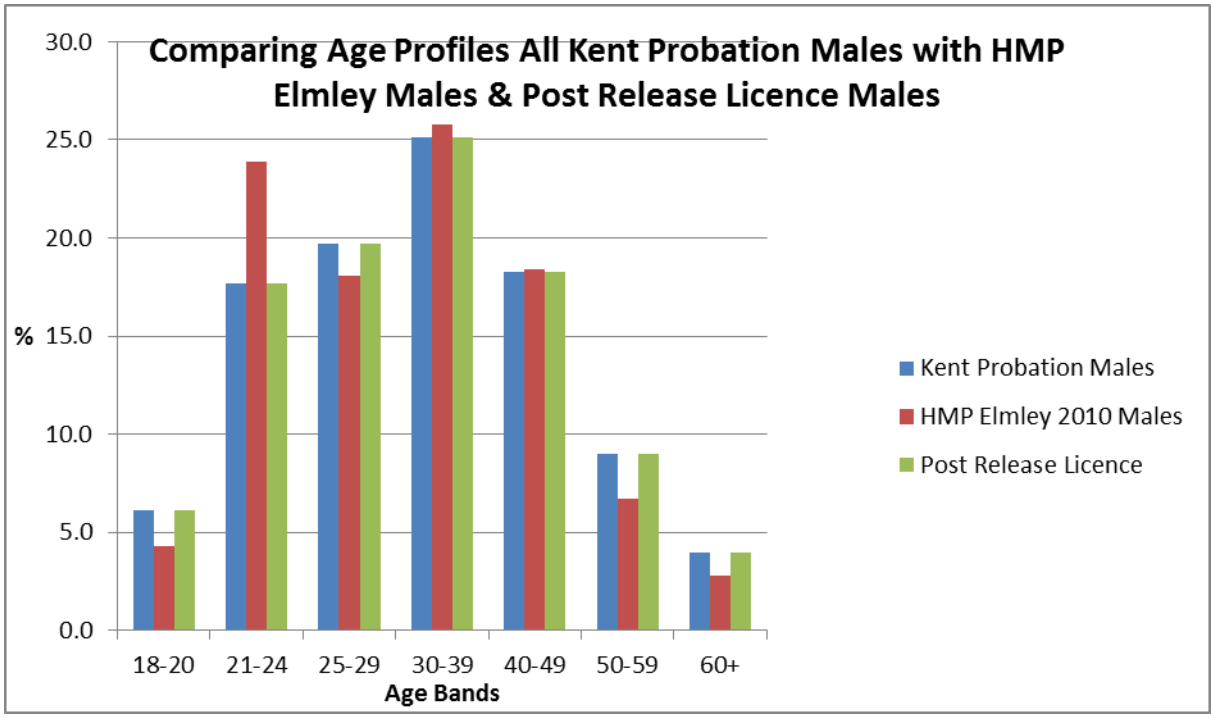


Chart 8 **Comparison of Kent Probation Male Community Offenders Age Ranges 2012 with HMP Elmley male population as percentages 2010 & Post Release Licence Males**

The Offender Group Reconviction Scale (OGRS) calculates the probability that a convicted offender will be convicted at least once within two years of their release from custody or from the start of their community sentence for any type of offence. The latest version (OGRS 3) is based on:

- age at the date of the current caution, non-custodial sentence or discharge from custody;
- gender;
- the type of offence for which the offender has currently been cautioned or convicted;
- the number of times the offender has previously been cautioned and convicted; and
- the length in years of their recorded criminal history.

Guidance for practitioners emphasises the strengths and limitations of OGRS and reminds them that while research shows OGRS to be a strong predictor of proven re-offending it is an aid not a substitute for judgment.

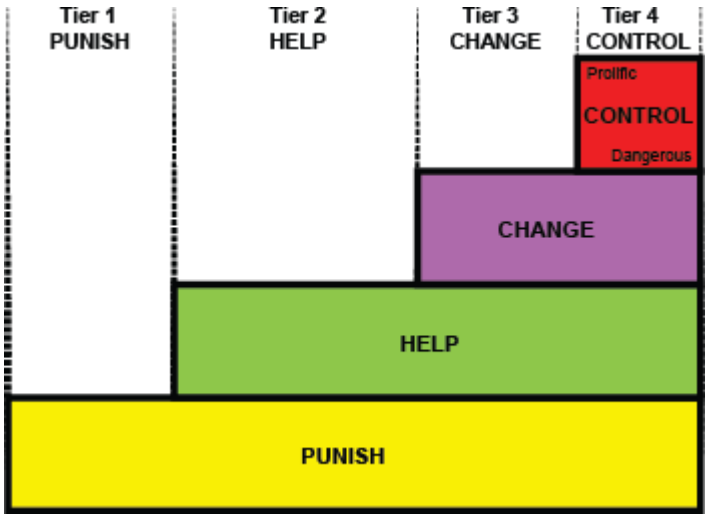


Chart 9 The Tiering Grid

Very High risk (Tier 4) offenders offer the highest risk of harm and Low Risk (Tier 1) the lowest. The assessment of offenders rating is updated continually throughout their order as their risk changes

Tier	Community Order	Suspended Sentence	Post Release Licence	Grand Total
Tier 1	530	213	14	757
Tier 2	445	239	320	1004
Tier 3	975	611	689	2275
Tier 4	45	63	143	251
Missing	8	8	1	17
Grand Total	2003	1134	1167	4304

Source Kent Probation

Table 7 Caseload by Tier

OGRS Band	Community Order	Suspended Sentence	Post Release Licence	Grand Total
Low	996	562	714	2272
Medium	614	327	273	1214
High	335	193	160	688
Very High	58	52	20	130
Grand Total	2003	1134	1167	4304

Source Kent Probation

Table 8 Caseload by OGRS band (Risk of proven reconviction)

Health and Well Being Survey

Interview framework and Outcomes

Kent Probation community offenders were invited to complete a health and wellbeing questionnaire to enable an assessment to be made regarding their health status as well as an understanding of a range of lifestyle behaviours which have an impact upon their general wellbeing. The questionnaire is attached in Appendix 1. It tried where ever possible to follow other previously managed examples of Community Offender health and wellbeing questionnaires which would hopefully offer the opportunity to compare the Kent and Medway prevalence rates/trends with other Probation Trust areas.

The initial intention was to offer individuals the opportunity to complete the questionnaire either unaided or with the assistance of a Health Trainer but a decision was made to dovetail the health and wellbeing questionnaire onto a general questionnaire process being undertaken by Kent Probation at that time. Some 1000 questionnaire forms were made available and at the end of the time period some 99 completed or partially completed forms were returned. Some additional forms were returned later but were not included in the initial analysis. They were assessed but gave no additional insight into the process.

The level of return was considered disappointing but given the characteristics of the population unsurprising. Clearly the exercise would have hoped for a higher return and fuller completion/disclosure and it gives rise to whether there is a need in the future to repeat the exercise but under more stringent controlled conditions.

Age and Gender

The gender split was 86% males 14% females (n=99) compared with a split of 87% male/13% female in the general Kent Probation population. (Nottinghamshire & Derbyshire and Hertfordshire both 86%/14% splits.)

Males

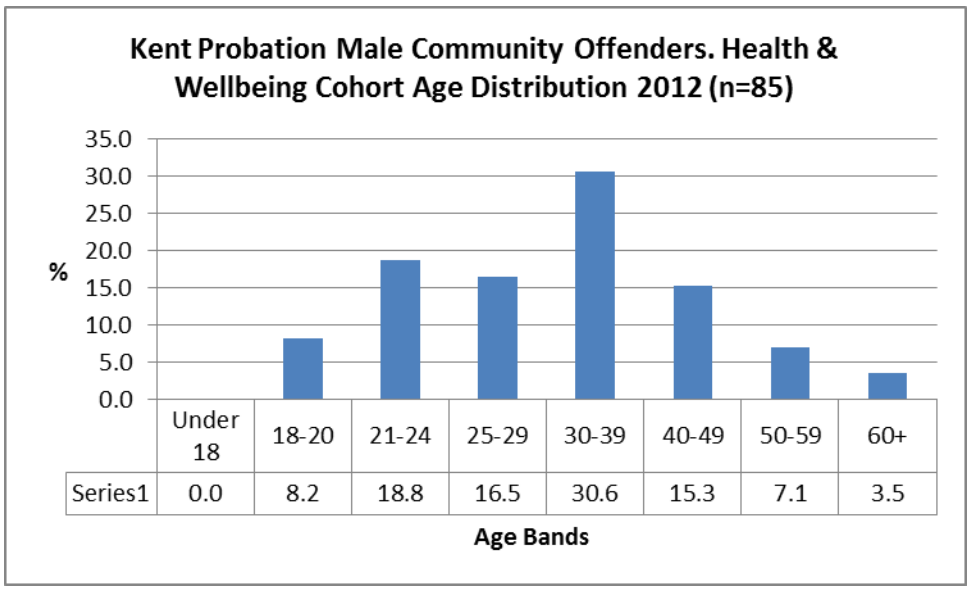


Chart 10 Kent Probation Male Community Offenders. Health & Wellbeing Cohort Age Distribution 2012

Females

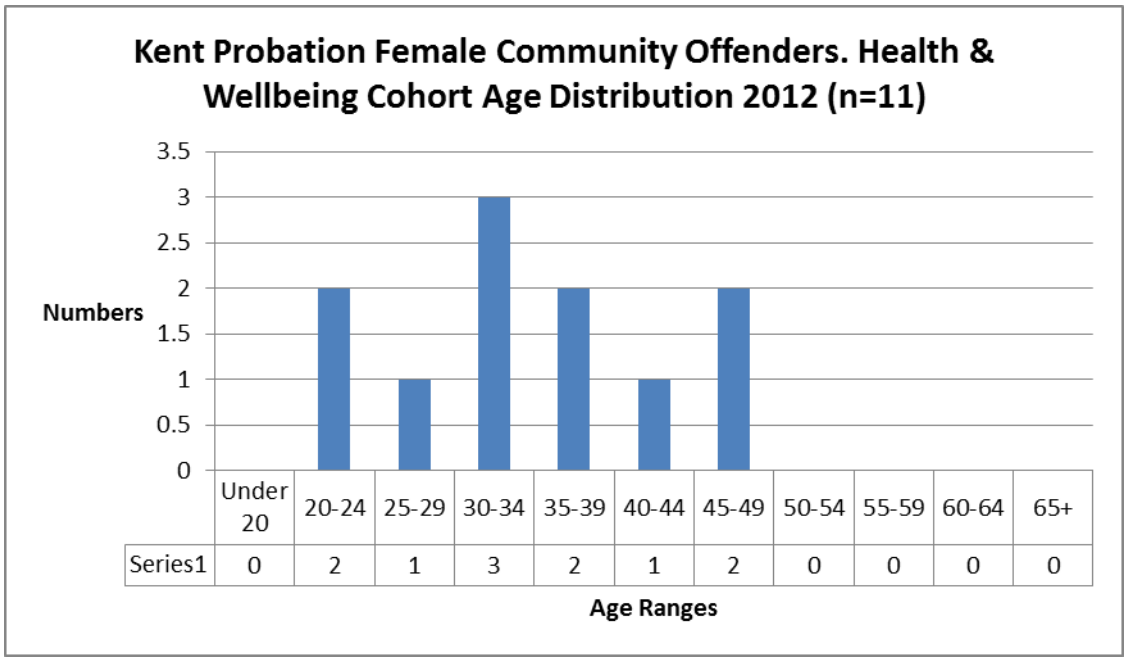


Chart 11 **Kent Probation Female Community Offenders. Health & Wellbeing Cohort Age Distribution 2012**

The adult male population was compared for age profile with initially the Probation Trust offender population and then the prison population of HMP Elmley to assess whether there was any compatibility given that this prison is the local prison for Kent and Medway Courts. The profile of the health and wellbeing survey population was slightly younger than that of the Probation population and broadly similar to that of HMP Elmley although that of the prison was a slightly younger group, particularly in the 21-24 age group.

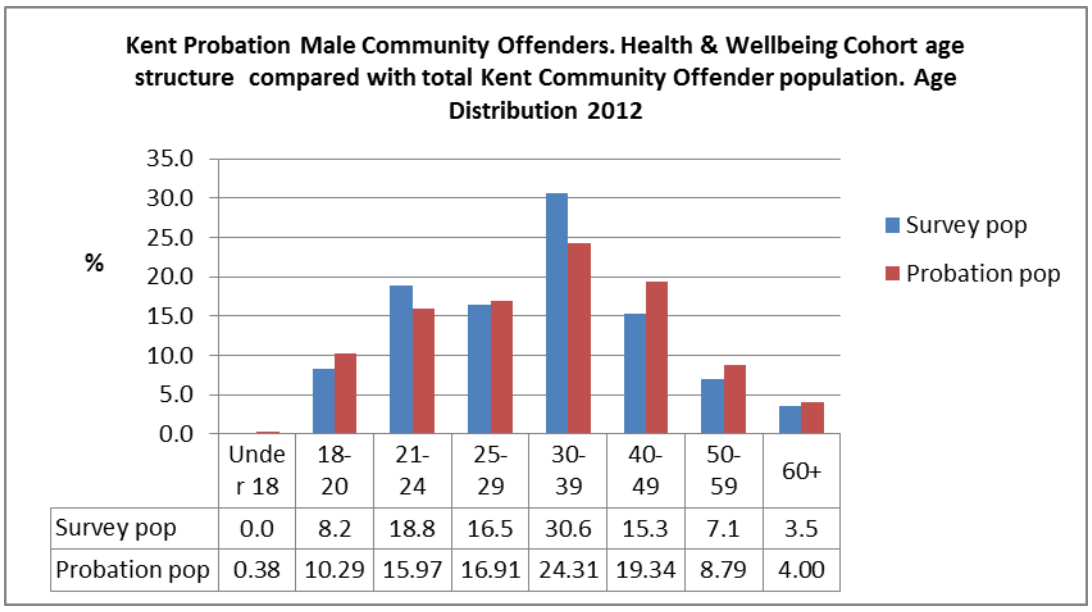
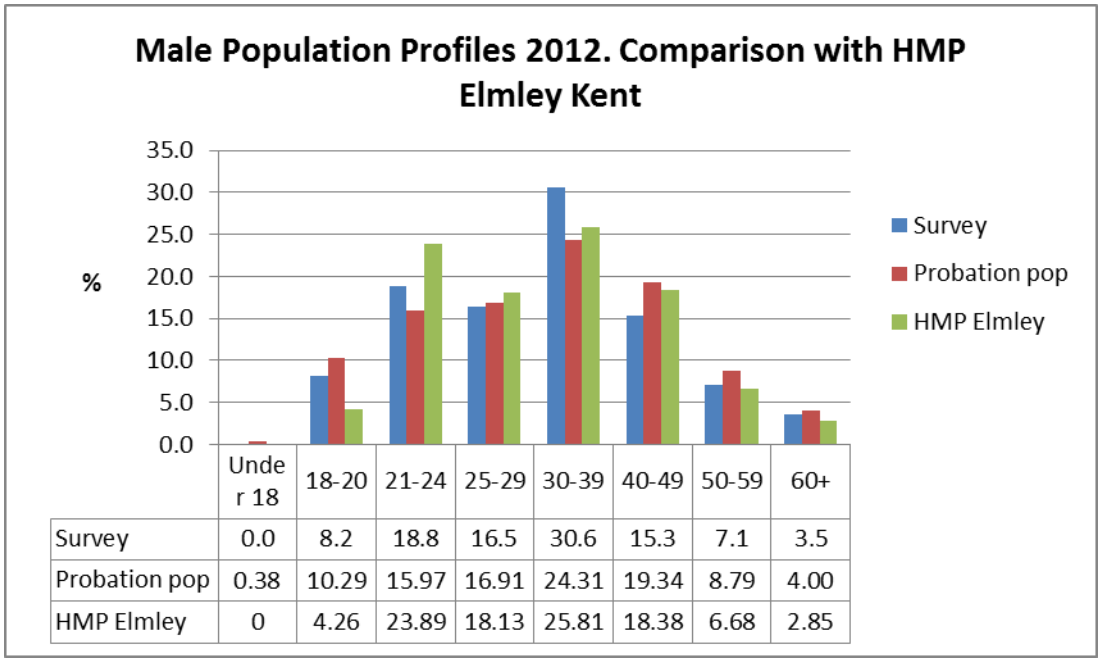


Chart 12 **Kent Probation Male Community Offenders. Health & Wellbeing Cohort age structure compared with total Kent Community Offender population. Age Distribution 2012**



	Under 18	18-20	21-24	25-29	30-39	40-49	50-59	60+
Survey	0.0	8.2	18.8	16.5	30.6	15.3	7.1	3.5
Probation pop	0.38	10.29	15.97	16.91	24.31	19.34	8.79	4.00
HMP Elmley	0	4.26	23.89	18.13	25.81	18.38	6.68	2.85

Chart 13 Male Population Profiles 2012. Comparison with HMP Elmley Kent

Comparing population profiles can in some instances be indicative of possible morbidity particularly in terms of offender populations.

Under 40 age groups	%
Survey	74
Kent Probation	69
HMP Elmley	72

Table 9 Comparison of Under 40 age groups

General Health Status

Disability

Of the cohort of 99, 13 offenders stated that they were registered disabled 2 being female, 10 male and 1 gender undisclosed.

Ethnicity

54 offenders disclosed their ethnicity with 52 stating that they were White and 1 each as Black and Asian. 45 failed to respond.

Self-Assessed Health Status

The offenders were asked to self-assess their health status with the results below (n=99):-

Self-Declared Health Status	Number of Offenders	% of Offenders
Excellent	14	14%
Very Good	26	26%
Good	28	28%
Fair	16	16%
Poor	14	14%
No Response	1	1%

Table 10 Offender Health Status

68% self- assessed as good or better which is lower than that expressed within the general population (76%) and 14% as poor which is higher than that express within the general population (4-8%)

This data was then further refined to link with location where it was known or assumed to be know from other information.

	Office					
Self-Declared Health Status	Canterbury	Chatham	Gravesend	Tonbridge	Tunbridge Wells	No Response
Excellent	7				3	4
Fair	2	1		1	6	6
Good	11		3		3	11
NR					1	
Poor	7	1	1		2	3
Very Good	2	3	8		8	5
Total	**29**	**5**	**12**	**1**	**23**	**29**

Table 11 Offender Health Status by Office (where known or assumed)

Self-assessed general health is an important indicator of the general health of the population. It is a valid measure for predicting future health outcomes and can be used to project use of health services and provide information useful for policy development. In older people, self-assessment of poor overall health has been associated with increased risk of mortality, and has also been reported to be predictive of functional decline.

Between 1993 and 2011, the proportion reporting very good and good general health has fluctuated between 74% and 78% among men and between 73% and 76% among women (77% and 76% respectively in 2011), with no clear pattern of variation. The prevalence of very bad or bad general health has ranged from 4% to 8% across both sexes over the same period.
Like self-reported general health, longstanding illness is a valuable indicator of the health of the population, and is also an important indicator of inequalities, with strong links between poverty, social class and self-assessed longstanding illness. As the population ages, the number of people with a longstanding illness or condition is expected to rise.

Personal care plans were introduced in 2006 as part of a strategy to support and empower people with long term conditions. The aim was to offer them to everybody with a longstanding illness by the end of 2010, and the strategy sought to place the patient at the centre of their care. The intention was that those with longstanding conditions should be able to make informed decisions about the treatment that they receive and be supported to live as independently as possible for as long as they can.

The prevalence of longstanding illness among men increased overall from 40% in 1993 to around 44% between 1997 and 2003, but appears to have decreased gradually over the last few years; it was 38% in 2011. Among women, prevalence increased from 40% in 1993 to 47% in 2004, but has since decreased and was 41% in 2011.

Acute sickness is defined as any illness or injury (including any longstanding condition) that has caused the participant to cut down in the last two weeks on things they usually did. The prevalence of acute sickness ranged from 12% to 16% of men and from 14% to 19% of women over the period 1993 to 2011.

Self - Declared Health Status	19-24	25-34	35-44	45-54	55-64	65+	No Response
Excellent	5	7	2				
Very Good	7	12	3	3			1
Good	5	11	7	4	1		
Fair	6	4	1	3	1	1	
Poor	2	2	3	3	2		2
NR							1
Grand Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**
Percentage (Age Bands)	**25.3%**	**36.4%**	**16.2%**	**13.1%**	**4.0%**	**1.0%**	**4.0%**

Table 12 Offender Health Status by Age Band

Self-Declared Health Status	Asian (A1)	Black (B1)	White British (W1)	No response
Excellent		1	4	9
Fair	1		8	7
Good			17	11
NR				1
Poor			8	6
Very Good			15	11
Total	**1**	**1**	**52**	**45**

Table 13 Offender Health Status by Ethnicity

Health Conditions

Long term conditions are those which cannot at present, be cured, but can be controlled by medication and other interventions. The life of a person with a long term condition is permanently altered – there is no return to "normal" (DH, 2008). Specific morbidities are more likely to affect those who offend. There is a greater risk of long term conditions such as COPD, CVD, cancer and hypertension, exacerbated by chaotic lifestyles including the use of illicit drugs, alcohol and smoking and these behaviours are more prevalent in offenders than in the general population

There is a greater prevalence of chronic physical disease among older prisoners than among the general older population (HMIP 2004). 85% of offenders in prison aged 60+ are likely to report at least one or more major illnesses in their medical records; and 83% are likely to report at least one chronic illness or disability (Fazel et al, 2001). In the Kent Probation population, a sizeable minority of offenders (32%) are aged over 40 years of age, so the prevalence of long term conditions are likely to be greater than in the general population. The expectation is therefore that the prevalence of long term conditions in this group would exceed that of the general population. However the relatively small numbers of these offenders will make percentage comparisons less meaningful. An expectation of matching the wider population profile for long term conditions is therefore a better benchmark.

They were also invited to disclose a health condition (chronic disease) 5 being specific (asthma, diabetes, mobility, heart & circulatory and mental health) and one relating to "other" health problems.

They were also invited to disclose whether they were seeking or receiving treatment for any disclosed condition.

The results are in Table 15 below by condition and age band and whether being treated.

Whilst 59 offenders disclosed at least one chronic condition some 93 specific examples of a chronic condition were disclosed some offenders having 2 or more conditions.

Chronic Disease	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total	Being Treated
Asthma	4	7	5	2				18	12
Asthma %	16%	19%	31%	15%				18%	67%
Diabetes		1	1		2			4	3
Diabetes %		28%	6%		50%			4%	75%
Mobility		2	1	5	1		2	11	8
Mobility %		6%	6%	38%	25%		50%	11%	73%
Heart/Circulatory		3	2	3		1		9	6
Heart/Circulatory %		8%	13%	23%		100%		9%	67%
Mental Health	6	6	8	7	2		2	31	22
Mental Health %	24%	17%	50%	54%	50%		50%	31%	71%
Other Condition	4	5	3	3	2	1	2	20	15
Other Condition %	16%	14%	19%	23%	50%	100%	50%	20%	75%

Table 14 Chronic Disease by Age Band

This data was then further interrogated to link with self-reported health status and chronic disease.

Self-Declared Health Status	Number Reporting No condition	Number Reporting a condition	% of None	% of Yes
Excellent	12	2	85.7%	14.3%
Very Good	17	9	65.4%	34.6%
Good	7	21	25.0%	75.0%
Fair	3	13	18.8%	81.3%
Poor		14	0.0%	100.0%
No response	1		100.0%	0.0%
Total	**40**	**59**	**40.4%**	**59.6%**

Table 15 Offender Health Status by reported chronic condition

This raises an interesting question around the 32 offenders who declared their health status as good or better and who had disclosed a chronic condition. One view could well be that these individuals do not consider the chronic condition as having too detrimental impact upon their life having lived with the condition and having it under control e.g. asthma.

On closer examination whilst noting that some of the offenders have stated more than one chronic disease, of the 32 offenders who self- declared health was Good-Excellent

14 had Asthma (11 just asthma, 3 with asthma plus at least one other condition)
11 had Mental Health problem (6 just Mental Health, 5 with other)
3 had Circulatory problem (2 just Circulatory, 1 with other)
3 Diabetes (1 just diabetes, 2 with other)
2 Mobility (1 just mobility, 1 with other)
7 Other problems

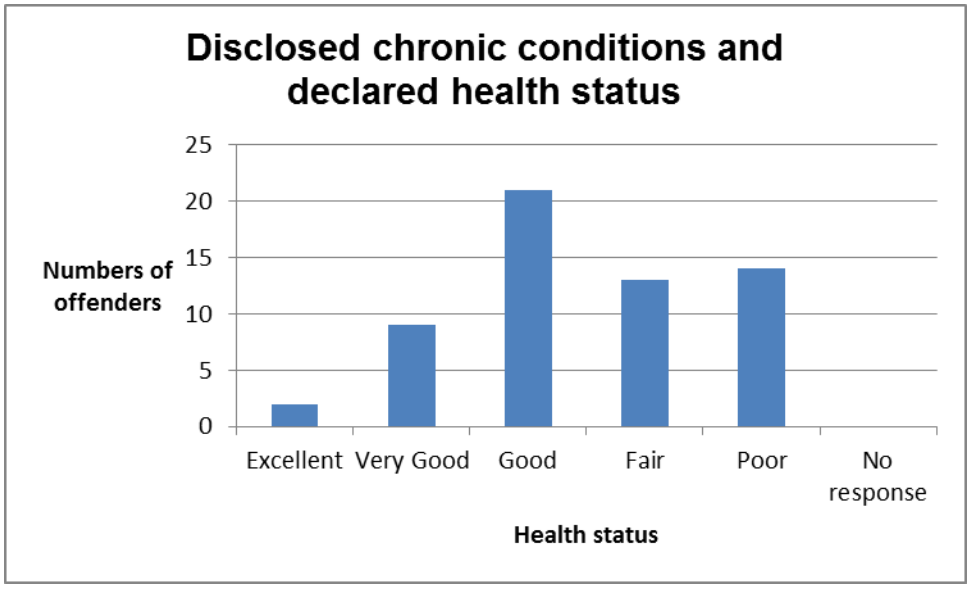


Chart 14 **Offender disclosed chronic condition and declared health status**

Self-Declared Health Status	Asthma	Diabetes	Mobility	Circulatory	Mental Health	Other
Excellent	1					1
Very Good	2		1	3	8	6
Good	7	1	2	3	9	6
Fair						
Poor	2	1	8	3	12	7
No response	6	2			2	
Total	**18**	**4**	**11**	**9**	**31**	**20**

Table 16 **Self-Reported Conditions by Self-reported Health Status (**note – some offenders had multiple morbidities)

Mental Health

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder. This compares to 16% for cardiovascular disease and 16% to cancer. 18% of adults have a common mental health disorder, 6% alcohol dependence and 3% drug dependence.

Mental health disorder during adulthood leads to poorer outcomes and inequalities:

- poorer educational achievement
- higher risk of homelessness
- higher rates of debt problems
- increased suicide and self- harm levels
- increased health risk behaviours, including poor diet, and less exercise.

The Kent and Medway Joint Strategic Needs Assessment for Mental Health cites that approximately one in one hundred people have a severe mental health illness and that one in six people has a mental problem at any given time. The majority experience a common mental health condition such as anxiety or depression (these terms cover a technical classification of six neurotic conditions). Given the size therefore of the community offender population of circa 4,303 then we should see prevalence rates of 1% (43) of severe mental illness and 16.6% (714) of common mental health conditions. However in this population prevalence would be expected to be higher given that there are causal links of mental health illness to deprivation as well as substance misuse.

Thanet, South Kent Coast and Canterbury are the CCGs have the highest case rate with psychiatric teams in Kent (in the first half of 2013). Hospital data in 2012 showed that Thanet had by far the largest proportion of patients admitted to hospital for schizophrenia (72 per 100,000 people) in Kent

NHS Kent and Medway knew from their Prison HNAs that there is a high prevalence of mental health disorders in offender populations. Also a brief review of the literature (Sondhi 2009) identified the very high prevalence rates of mental health disorders among offender populations. These figures vary from around 72% of male prisoners (Goggins, 2008) to 90% of all prisoners, although this figure includes alcohol misuse and drug dependencies in addition to neurosis, psychosis and personality disorders (National Addiction Centre/Department of Health, 2003). The NHS also estimates that 5-8% of all offenders may have “severe and enduring” mental illness (DH 2007).

The prevalence of depression is much higher with offenders in the criminal justice system, and severe mental health conditions also appear to be much more prevalent than in the general population. Currently services in prison tend to be specialist provided for mental health and focus upon the more seriously ill.

The evidence base also highlights the relationship between the offender’s mental health and wider health or social determinants including;

- Homelessness or living at no fixed abode (NFA). Nearly a third to half of offenders in this category may have a mental illness. (Singleton et al 1997).
- Violence in the home – with a quarter of men in prison reporting suffering from violence between partners and other family members (Meltzer et al 2002)
- Misuse of alcohol and/or illicit drugs (Holloway et al 2006). There is a need to consider mental health issues holistically as there will be higher rates of dual diagnosis among illicit drug and alcohol misusers. For example, nearly three quarters (70%) of offenders being treated by mental health in-reach teams have substance misuse problems and

despite this level of prevalence the HMIP Inspectorate identified in 2008 that few prisons had adequate dual diagnosis skills

The key component within the NHS Kent and Medway strategic plan is to reduce the incidence and prevalence of mental health disorders.

Mental Health Needs Assessment 2007

The most recent Mental Health Needs Assessment focused upon offenders was carried out across the Kent and Medway Prison estate in 2005/06 and published in 2007 by the Kent Forensic Psychiatric Services. There was no assessment of Community Offenders at that time and since then.

In terms of mental health morbidity of the cohort of 99 of the 59 who confirmed the presence of a long term condition 31 stated that they had a mental health condition with 20 stating that they had a co-morbidity with another condition(s) – 5 with asthma, 15 with another chronic disease(s) and 11 with a mental health condition only. Of the 20 offenders with co morbidity 16 were in treatment whilst only 5 of the 11 disclosed mental health conditions were in treatment. Therefore of this cohort 31% stated that they had a mental health condition which is higher than the prevalence rate of published figures for Hertfordshire (28.1%) and Nottinghamshire and Derbyshire (27.3%) but lower than the Kent Probation OASys data of 50.2%. (See below)

28 offenders gave no response and 12 stated that they did not have a chronic disease including a mental health condition.

Data from taken from OASys relating to physical and mental health status as disclosed by clients on interaction with their Probation Officers shows the figures below in Table 16.

	Count	Percentage
Physical Health	2426	40.2%
Mental Health	3031	50.2%
Physical & Mental	1684	27.9%
Total Offenders	6036	-

Source: Kent Probation

Table 17 Kent Probation data relating to health status 2012

Other Mental Health Wellbeing Data

Mental health and wellbeing refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships.

The community offenders were invited to comment upon the impact of any emotional problems such as depression or being anxious had on their regular daily activities. This centred upon three areas namely cutting down on the amount of time they spent on work or other activities, accomplishing less than they would like and finally any problems with sleeping.

Of the 99 offenders 20 gave no response and 46 confirmed that they did have problems. Approximately 85% had problems associated with sleeping.

Area	Numbers	%
Sleep	12	26.1
Less work	1	2.2
Activities	4	8.7
All 3	12	26.1
Sleep/less	12	26.1
Act/less	2	4.3
Act/sleep	3	6.5
	46	100.0

Table 18 General Mental Health well-being

This data was then applied to three areas of lifestyle choices, smoking, drinking alcohol and substance misuse.

Lifestyle Choice	Admit to accomplishing less	% that admit to accomplishing less	Cut down on activities	% who cut down on activities	Trouble sleeping	% having trouble sleeping
To Smoke	22	81%	16	76%	24	62%
To Drink Alcohol	17	63%	14	67%	24	62%
To Take Drugs	7	26%	6	29%	8	21%

Table 19 Lifestyle Choices and general Mental Health

Self-Declared Health Status	Cut down on Activities	Cut down on Activities %	Accomplish Less	Accomplish Less %	Sleep problems	Sleep problems %	None	None %
Excellent	1	7%	2	14%	1	7%	12	86%
Very Good	5	19%	3	12%	7	27%	16	62%
Good	7	25%	10	36%	14	50%	12	43%
Fair	3	19%	6	38%	9	56%	7	44%
Poor	5	36%	6	43%	8	57%	5	36%
No response		0%		0%		0%	1	100 %
Total	**21**	**21%**	**27**	**27%**	**39**	**39%**	**53**	**54%**

Table 20 Community Offender health status and general Mental Health

Data provided by Kent Probation from their OASys data based recorded the community offenders answers to 6 areas of status around emotional well-being – Difficulties Coping, Psychological Problems / Depression, Social Isolation, Offender's Attitude To Themselves, Self-Harm / Attempted Suicide / Suicidal Thoughts, and finally Psychiatric Problems. The Tables below show the response from the offenders but it should be noted that a significant number have not had their response recorded – overall some 35%.

'Missing data' in OASys means that at the time of completing the OASys assessment, the Offender Manager (OM) did not have any information available relating to that particular

question/ offender 'need'. As the OM continues to manage the case, such information may come to light either from the offender or from another source which means that the OM should then update that particular field.

Difficulties Coping (1)	Community	Licence	Grand Total
No problems	842 (36%)	660 (54%)	1502 (42%)
Some problems	1066 (46%)	417 (34%)	1483 (42%)
Significant problems	411 (18%)	141 (12%)	552 (16%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100)	1743 (100%)	5464 (100%)

Psychological Problems / Depression (2)	Community	Licence	Grand Total
No problems	1236 (53%)	851 (70%)	2087 (59%)
Some problems	741 (32%)	286 (24%)	1027 (29%)
Significant problems	342 (15%	81 (6%)	423 (12%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100%)

Social Isolation (3)	Community	Licence	Grand Total
No problems	1488 (64%)	851 (70%)	2339 (66%)
Some problems	653 (28%)	281 (23%)	934 (26%)
Significant problems	178 (8%)	86 (7%)	264 (8%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100%)

Offender's Attitude To Themselves (4)	Community	Licence	Grand Total
No problems	1242 (54%)	795 (65%)	2037 (58%)
Some problems	904 (39%)	357 (29%)	1261 (36%)
Significant problems	173 (7%)	66 (6%)	239 (6%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100%)

Self-Harm / Attempted Suicide / Suicidal Thoughts (5)	Community	Licence	Grand Total
No	1645 (71%)	939 (77%)	2584 (73%)
Yes	674 (29%)	279 (23%)	953 (27%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100%)

Psychiatric Problems (6)	Community	Licence	Grand Total
No problems	1775 (77%)	1060 (87%)	2835 (80%)
Some problems	366 (16%)	108 (9%)	474 (13%)
Significant problems	178 (7%)	50 (4%)	228 (7%)
(blank)	1402 (38%)	525 (30%)	1927 (35%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100%)

Table 21 Emotional Well-being data from Kent Probation OASys database.

Personality Disorder (PD)

In respect of the community offender personality disorder strategy Kent Probation are developing some interesting work. The DoH and NOMS have jointly funded a workforce development programme for probation staff. In Kent they have partnered with KMPT. They jointly developed a bid to provide experienced psychologist cover for each of their LDU's (local delivery units) and to their Approved Premises, Fleming House. The purpose of the project is to provide psychological advice and guidance to Probation staff managing men and women with probable PD. The other criteria include high risk of harm and a history of sexual and/or violent offending. The 'probable' refers to the fact that the project is focussing on people who present with interpersonal difficulties rather than providing diagnostic assessments. This latter work would monopolise the psychologist time and it was felt that they could have greater impact on a wider group by working with the staff and enabling them to work more effectively.

The project covers case identification set against criteria. This criteria is contained within the service specification for Community Based Services for Offenders likely to have a Personality Disorder. This is a two stage process of a list being generated from the Probation OASys system and the psychologist meeting with each Offender Manager to go through their case load. The next stage is case consultation and if necessary case formulation and sentence pathway planning. For some people this will mean minimal input but for others trying to understand what is driving their presentation is more important. At the Approved Premises group supervision and staff training is taking place. Group workshops are also being delivered in the LDU's.

Kent Probation also include a further day a week for working with the facilitators of the women's SAR (Specified Activity Requirement) which is a group work programme for women offenders. The psychologist is assisting the facilitators in the development of this work and coping with the emotional challenges that working with the women brings.

The project team are looking at personality disorder across all diagnoses although they suggest that the most prevalent in their caseload would be ASPD, Borderline, Schizoid and Paranoid.

The project started in May 2013 and has had phased recruitment of the four psychologists and administrator. The project lead, who is a Senior Forensic Psychologist, also has a day a week dedicated to the project which is due to run until at least 2015. The initial case load identified from the OASys document was 2110 men and 206 women with about 100 new cases per month needing to be screened. This represents some 54% of the total population (see Table 5 page 16), and some 56% and 37.5% of the male and female cohorts respectively. However it is anticipated that only about 10% of this number will require the full case consultation and fully meet the high risk, probable PD criteria representing between 4%-6% of the community offender population.

Kent Probation also commission mental health counselling which is recognition of the role that specialist support with personal and emotional issues can play in enabling an offender make and sustain positive changes in life-style. A contract is in place with KCA with a specification requiring a minimum of 131 sessions per year. In terms of volume of activity, KPIs (Schedule 2 of the contract) are met and exceeded, resulting in around 700 sessions delivered.

Fruit and vegetable consumption

In 2002 the World Health Organisation (WHO) began to develop a global strategy on diet, physical activity and health in the context of the rising burden of chronic diseases. Diseases like cardiovascular disease, stroke, diabetes and cancer present a major challenge to public health, particularly in developed countries. These diseases, and the associated unhealthy behaviours, cluster among poor communities and contribute to social and economic inequalities.

A 2005 report estimated that food-related ill health in the UK is responsible for about 10%of deaths and illness, costing the NHS £6 billion annually. The vast majority of this burden is due to unhealthy diets rather than food-borne diseases. Dietary goals to prevent chronic diseases emphasise eating more fresh vegetables, fruits, and pulses. The '5 A DAY' guidelines were developed based on the recommendation from the WHO that consuming 400g fruit and vegetables a day can reduce risks of chronic diseases, e.g. heart disease, stroke, and some cancers. These guidelines state that everyone should eat at least five portions of a variety of fruit and vegetables every day. Fruit and vegetables may also play an important role in weight management when combined with reduced fat intake, and may reduce the risk of Type 2 diabetes and impaired cognitive function.

Questions about fruit and vegetable consumption were first included in the Health Survey for England in 2001, were designed to assess fruit and vegetable consumption in terms of portions per day (roughly 80g per portion). For both men and women, the proportion that consumed five or more portions per day increased significantly to a peak in 2006, from 22% in 2001 to 28% in 2006 among men, and from 25% to 32% among women. However, the proportion of adults consuming five or more portions a day was significantly lower in 2008, when 25% of men and 29% of women reported consuming five or more portions. The 2011 results are at a level comparable with 2008

Amongst the cohort of Kent Probation offenders (n=99), 40 gave no response to the question "have you heard of 5 a day" and of those who did respond 56 said that they had and 3 replied that they had not. Clearly the message is getting through about the importance of fruit and vegetable consumption.

However in terms of fruit and vegetable consumption 21 gave no response to the question relating to daily consumption and of those 78 who did 19% consumed 5 or more portions which is below the national prevalence rate cited above. If the no response individuals are discounted the rate then rises to 24% which is close to the national figure.

There is clearly a need to promote the greater consumption of fruit and vegetables which will be linked to lifestyle, access to healthy cooking and food preparation and affordability.

5 a day?	19-24	25-34	35-44	45-54	55-64	65+	No response	Total
No	1	1	1					**3**
No Response	10	12	7	4	3	1	3	**40**
Yes	14	23	8	9	1		1	**56**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**56%**	**64%**	**50%**	**69%**	**25%**	**0%**	**25%**	**57%**

Table 22 Community offender knowledge of the "5 a day" scheme

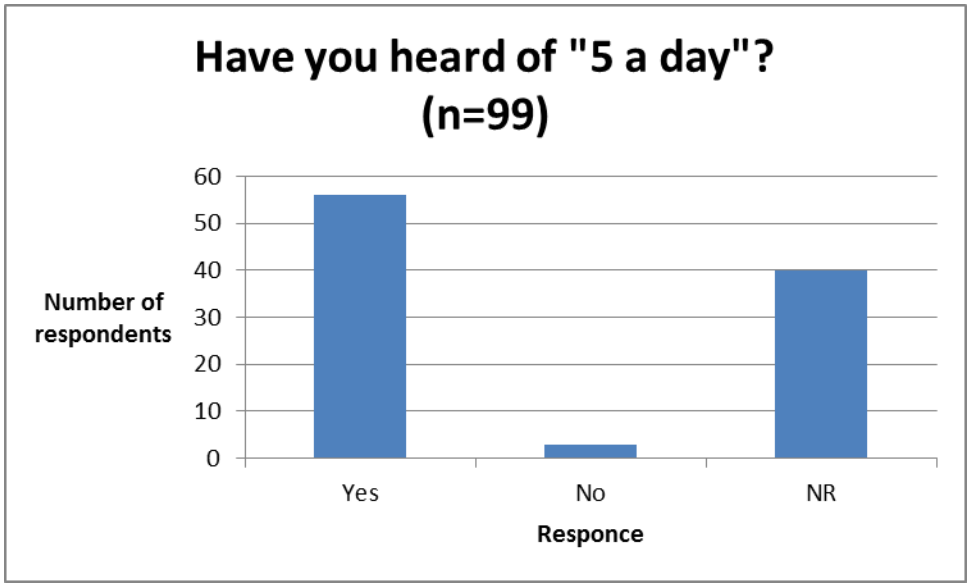


Chart 15 Have you heard of "5 a day"?

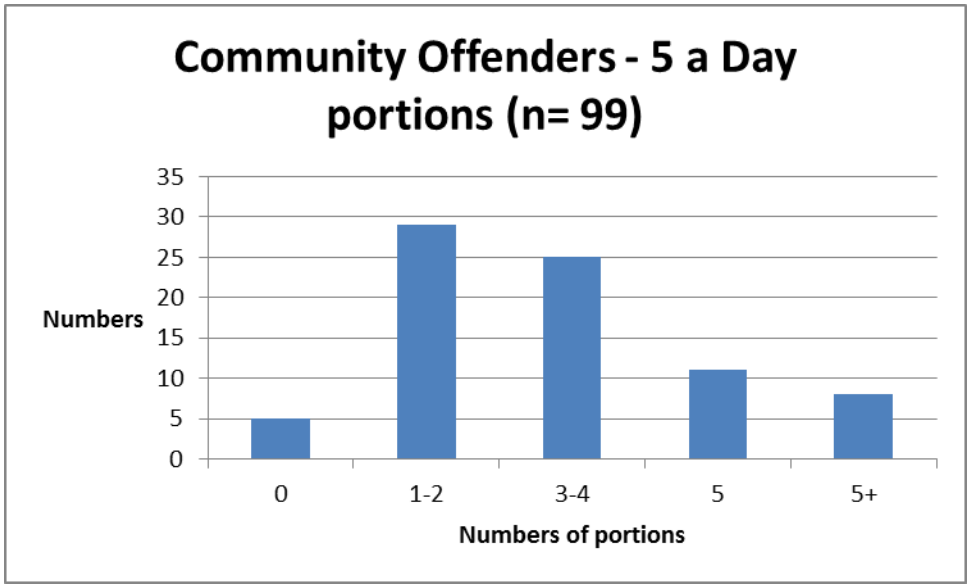


Chart 16 Community Offenders - 5 a Day portions

19 respondents reported actually eating 5 or more a day, 11 of whom reported having a chronic disease

Physical activity

Physical activity has become an increasingly important public health issue as governments attempt to curb the levels of child and adult obesity. The health benefits of a physically active lifestyle has been well documented. Physical inactivity is associated with many chronic conditions, including ischaemic heart disease, diabetes, osteoporosis, certain types of cancer, as well as obesity, which itself contribute to many of these diseases.

In England, physical inactivity was estimated in 2002 to cost £8.2 billion a year. The World Health Organisation (WHO) rated physical inactivity as one of the leading causes of death in developed countries. The time spent sedentary is at least as important as moderate intensity physical activity as a disease risk factor: sedentary behaviours are also associated with increased risk of obesity and cardiovascular disease independently of moderate to vigorous activity levels.

Increasing physical activity among adults has been a subject of public health promotion policies and government health strategies in England since the early 1990s. Guidelines for physical activity for maintaining optimal health have been available since the mid to late 1970s. Recent National Institute for Health and Clinical Excellence (NICE) guidance highlights the contribution of regular physical activity to promoting the health of communities. In 2004, the Chief Medical Officer (CMO) published recommendations that adults should be active at moderate or greater intensity for at least 30 minutes a day either in one session or through shorter bouts of activity of 10 minutes or longer, on at least five days a week; these guidelines were updated in 2011. The recommended targets can be achieved through lifestyle activity, or structured exercise or sports, or a combination of these.

In 2008, the Department for Culture, Media and Sport published *Playing to Win*, which focuses on increasing sport participation by 2012, the London Olympics, particularly among children and young people. The government has also produced policy, programmes and additional targets in an attempt to increase levels of activity in the general population. The Department of Health recently published *Be active, be healthy: A plan for getting the nation moving*, which outlined strategies to increase physical activity.

The Health Survey for England 2011 showed the proportion achieving different levels of physical activity in 1997, 1998, 2003, 2004, 2006 and 2008; these levels are based on self-reported activities in the last four weeks. For 2008, the module of questions on physical activity was revised and an enhanced questionnaire was developed. Full details of the questionnaire revisions were provided in the 2008 report; the main changes for 2008 were additional questions to provide more accurate data on occupational activity and sedentary time, more detail about certain types of exercise, and allowing bouts of 10 minutes of activity to be accrued towards meeting government physical activity recommendations.

In previous years the physical activity levels have been labelled high, medium and low; in 2008 the categories have been renamed to describe more accurately what they represent. The category formerly labelled 'high' is in fact the group that meets government recommendations for the minimum level of activity to achieve health benefits (e.g. reduction in the relative risk for cardiovascular morbidity). Definitions of these categories are as follows:

- Meets recommendations: 30 minutes or more of moderate or vigorous activity on at least five days per week
- Some activity: 30 minutes or more of moderate or vigorous activity on one to four days per week
- Low activity: lower levels of activity.

Using the original method to obtain directly comparable measures between 1997 and 2008, it is evident that the proportion meeting recommendations for levels of physical activity has increased among both men and women. This has been a gradual increase over the period, from 32% in 1997 to 42% in 2008 for men, and from 21% to 31% for women. For both sexes the proportion reaching this level of activity decreased steadily as age increased.

The revised method for estimating adults' levels of physical activity provided slightly lower estimates of the proportion of adults meeting government recommendations for physical activity. The revised method indicated that 39% of men and 29% of women had met recommendations, compared with 42% and 31% respectively using the original method.

The responses from those completing the questionnaire are below appearing to give support to the view that these guidelines are being partially met.

Moderate Exercise	**19-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**No response**	**Grand Total**
No	2	3	2	3	1			**11**
No Response	5	5	5	2	2		2	**21**
Yes	18	28	9	8	1	1	2	**67**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**72%**	**78%**	**56%**	**62%**	**25%**	**100%**	**50%**	**68%**

Table 23 Community Offenders who do 'moderate' exercise each day

Weekly Strenuous Exercise	**19-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**No response**	**Grand Total**
No	6	12	3	7	2	1	1	**32**
No Response	6	5	5	2	2		2	**22**
Yes	13	19	8	4			1	**45**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**52%**	**53%**	**50%**	**31%**	**0%**	**0%**	**25%**	**45%**

Table 24 Community Offenders who do strenuous weekly exercise

Smoking

Smoking is the single greatest cause of preventable illness and premature death in the UK. Figures from the report *Statistics on Smoking: England, 2012* showed that in England in 2011 smoking contributed to around 79,100 deaths, accounting for 22% of deaths in men and 14% of deaths in women aged 35 and over. These included around 37,400 deaths from cancers, 22,500 deaths from respiratory diseases, 18,100 deaths from circulatory diseases and 1,100 of deaths from diseases of the digestive system. It is also estimated that around 5% (459,900) of all hospital admissions in England among adults aged 35 and over in 2010/2011 was attributable to smoking. The cost to the NHS of treating smoking related illness was estimated to be £5.2 billion per year in 2005/2006.

Since 1998, when *Smoking kills: a White Paper on tobacco* was published, cigarette smoking prevalence among adults has gradually declined from 28% to 21%. *Smoking kills* stated that smoking rates among adults should be 21% or lower by 2010, with a reduction in prevalence among routine and manual occupational groups to 26% or less. In 2004, the government of the time set out its strategy to tackle smoking and the effects of smoking on other people in the white paper, *Choosing Health: Making healthy choices easier*. Since then a number of proposed initiatives have been implemented, including the introduction of smokefree legislation in England from the 1st July 2007, the introduction of picture health warnings on cigarette packets from 1st October 2008, and raising the minimum age for sale of cigarettes from 16 to 18 from 1st October 2007.

More recently, in February 2010, the then government published their comprehensive tobacco control strategy entitled *A Smokefree Future*. This contained a number of aspirations for the forthcoming decade, including reducing adult smoking rates to 10% or lower by 2020 and halving current smoking prevalence rates among routine and manual groups and among those living in the most disadvantaged areas.

Among men there was an increase overall in the proportion who had never regularly smoked cigarettes (from 39% in 1993 to 49% in 2011). Correspondingly, the proportion of men who were current smokers declined overall from 28% in 1993 to 23% in 2011, as did the proportion that used to smoke regularly (from 33% to 28%). The proportion of men who smoked 20 or more cigarettes per day fell from 11% in 1993 to 5% in 2011. The proportion who smoked fewer than 10 cigarettes or 10 to 19 cigarettes per day showed no significant change (9% in each case in 2011).

The proportion of women who had never regularly smoked increased from 52% in 1993 to 59% in 2011, while the proportion of current smokers decreased overall in the same period, falling from 26% to 19%. As with men, there were no significant changes in the proportion of women who smoked fewer than 10 cigarettes per day (7% in 2011). Among women there was a significant decrease in those who smoked 10 to 19 cigarettes per day (11% in 1993 to 8% in 2011) and in those who smoked 20 or more cigarettes per day (from 8% to 3% over the same time period).

It is notable that while the prevalence of cigarette smoking has decreased among most age groups among both men and women, there has been no significant change over the period among men aged 25-34, the group most likely to be current smokers in 2011. In contrast, the largest decrease in prevalence of smoking has taken place among women aged 16-34, although younger women remained more likely to smoke than those aged 55 and over.

Amongst the cohort of Kent Probation offenders (n=99), 21(21%) gave no response and of those that did 53**%** (53) smoked and 25% did not (25). The prevalence rate in Kent for the adult population is approximately 25% and in Medway some 23%. The latest synthetic estimates in the draft Kent JSNA 2013 for adult smoking prevalence in Kent is 20.1%. It

should be noted that prevalence rates for smoking vary according to areas of deprivation and in Medway range from 21% at best to 37% at worst. We know that the prevalence rate in the prison offender population is approximately 80% but this can vary from prison to prison. This Kent & Medway population of community offenders is therefore closer to the prison population norm although this rate for Kent Probation may be considered to be to low given smoking prevalence rates in the offender population. HMP Standford Hill, an Open prison has the lowest smoking prevalence rate in the Kent estate at 58%.The smoking prevalence rate amongst community offenders in Hertfordshire is 77.6% and in Nottinghamshire and Derbyshire 83.1%.

The survey also gave an insight into the number of cigarettes smoked per day

Smoked	Numbers	%
0-9	6	11.8
10-19	27	52.9
20-29	13	25.5
30-40	5	9.8
	51	100.0
Unknown	2	

Table 25 Numbers of Cigarettes smoked per day.

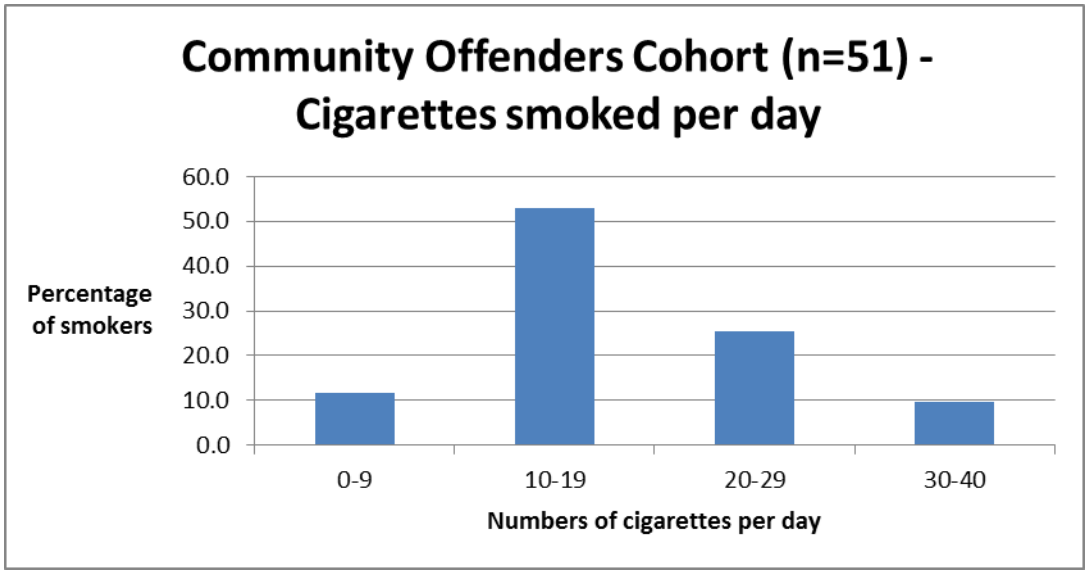


Chart 17 Percentage of Smokers and Smoking Rate

Do you smoke	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
No	5	7	3	6	1	1	2	**25**
No Response	5	5	5	2	2		2	**21**
Yes	15	24	8	5	1			**53**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**60%**	**67%**	**50%**	**38%**	**25%**	**0%**	**0%**	**54%**

Table 26 Numbers of Offenders smoking by age band

How many per day	19-24	25-34	35-44	45-54	55-64	Grand Total
3	1	1				**2**
5	1	1	1			**3**
6		1				**1**
10	5	10	4			**19**
12	1					**1**
15	2	3	1	1		**7**
20	4	4	1	3	1	**13**
30		3	1			**4**
40	1					**1**
No Response				1		**1**
Yes		1				**1**
Grand Total	**15**	**24**	**8**	**5**	**1**	**53**

Table 27 Number of cigarettes per day by age band

18% smoked 20 or more cigarettes per day, 8% more than 10 and less than 20 and 25% 10 or less cigarettes per day.

Of the 53 that smoke, 32 have thought about quitting, of which 7 wanted information on available help

38 of the 53 smokers also drink alcohol, 12 of the 53 take drugs and 6 of the 53 take drugs and alcohol

35% of smokers are smoking more than 20 cigarettes and with an average cost of 32p per cigarette (manufactured) or £16 for 50g of loose tobacco (20 cigarettes) it raises affordability questions about this cohorts smoking behaviour. Smoking is now considered an expensive habit and can give rise to tensions on spending priorities. It also poses a predilection for those on limited incomes to seek cheaper or illegal sources of tobacco along with re-offending behaviour to supplement spending on the product. Improved smoking cessation rates can therefore lead to better health as well as offending behaviour.

42% of all tobacco consumed in England is smoked by people with a mental health disorder

The current 2013/14 review of the Kent Stop Smoking Services should examine ways to better deliver these services to this community offender population.

Alcohol Consumption

Drinking alcohol is generally recognised as an established part of British culture and most British adults drink alcohol, at least occasionally. Yet concern has increased in recent years among policy makers, health professionals and the general public about the damage caused by excessive drinking to individuals, communities and society as a whole. Following a wide-ranging review of the current extent and nature of alcohol-related harms, the *Alcohol Harm Reduction Strategy for England* was first published in 2004, with a further report, *Safe. Sensible. Social. The next steps in the national alcohol strategy* in 2007. HM Government published the Government's Alcohol strategy in March 2012 which made specific reference to offenders.

Alcohol has been identified as a causal factor in more than 60 medical conditions, including mouth, throat, stomach, liver and breast cancers; hypertensive disease (high blood pressure), cirrhosis and depression. The annual cost to the NHS of alcohol misuse has been estimated as £2.7 billion at 2007 prices. Both hospital admissions for conditions specifically related to alcohol and deaths attributed to alcohol increased substantially between the early 2000s and 2010/11. These trends have been ascribed to a long-term increase in the amount of alcohol drunk in this country. From 1990, the average amount drunk each year increased from 9.8 litres of pure alcohol per head to a peak of 11.6 litres in 2004, though it has since declined to 10.2 litres in 2009.

Over time, as households' disposable incomes have increased, alcohol has become more affordable; taking 1980 as a baseline, in 2011, the affordability of alcohol had increased by45%. Over the same period, the proportion of household expenditure spent on alcohol fell from 9.6% to 4.7%.The pricing of alcohol has recently moved to the centre of public debate. In 2010 £42.1 billion was spent on alcohol in England and wales alone.

From 2006, changes were made in the way the Health Survey for England and other surveys estimate alcohol consumption. The changes have an impact on the estimated consumption of beer, wine and alcopops; the most significant of these is the revision to the unit equivalent of a glass of wine. In 2006, the conversion for a glass of wine was changed from one unit to two units; in 2007, a further adjustment was made and separate conversion rates were used for 125ml, 175ml and 250ml wine glasses.

Current government guidelines advise that daily drinking should not regularly exceed four units for men and three units for women. The proportion of men consuming more than four units on the heaviest day's drinking in the last week did not show substantial change between 2006 and 2011 (39% in 2011), and similarly the proportion of men that drank more than twice the recommended amount showed little change over the period (22% in 2011). The picture was different among women: there was a decrease between 2006 and 2011 both in the proportion consuming more than three units on the heaviest day's drinking last week (from 33% to 28%), and in the proportion drinking more than twice the recommended amount (from 16% to 13%).

Increasing risk consumption, higher risk alcohol consumption or alcohol dependency will have significant health effects for an individual over the short and long term. The main effects from alcohol misuse are described in the table below.

	Short Term Effects	Long Term Effects
Physical	Hypertension Accidents & falls	Cardiovascular disease Cirrhosis, Cancers, Strokes Neurological disorders
Psychological	Aggression Suicides	Sleep disturbance Depression
Social	Violence Domestic Abuse	Reduced achievement in work/education Acquisitive crime Relationship breakdown

TABLE 28 The general effects of problematic/hazardous drinking (National Addiction Centre/DH 2003)

The Social Exclusion Unit (2002) notes that 63% of men in the prison population report drinking at hazardous levels, compared with 38% of men in the general population.

The cohort of offenders was asked about alcohol consumption and their replies are below.

Alcohol	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
No	6	10	4	3			1	**24**
No Response	6	5	5	2	3		2	**23**
Yes	13	21	7	8	1	1	1	**52**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**52%**	**58%**	**44%**	**62%**	**25%**	**100%**	**25%**	**53%**

TABLE 29 Do you drink alcohol?

7 of the 52 who drink also take drugs. 10 Offenders took neither drugs, alcohol or smoked

They were also asked about the numbers of drinks they consumed per day and of those who disclosed alcohol consumption some 22% were drinking at hazardous and harmful levels.

Number of drinks per day	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
0	6	7	4	3			1	**21**
1	2	3				1		**6**
2	1	2						**3**
3		2						**2**
4	1	2						**3**
Between 5 and 10	3	1		3				**7**
Between 10 and 20	2	2	3	1				**8**
More than 20		4	1	1	1			**7**
No Response	10	13	8	5	3		3	**42**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**

TABLE 30 Number of drinks per day

Just 3 offenders wanted more information on local alcohol support services

Whilst the question related to the number of drinks per day rather than units, it suggests that a significant proportion of community offenders are drinking at either increased and or high risk levels. In Kent some 18.2% and 4.3% of the adult population drink at increased and high risk levels respectively. (Kent JSNA 2013).

The amount of alcohol drunk in terms of quantity is very much under declared.

Data from the OASys system relating to alcohol consumption and other relevant alcohol habits in 2012 shows the following.

Binge Drinking / Excessive Alcohol in last 6 Months	Community	Licence	Grand Total	Community %	Licence %
No problems	2140	1422	3562 (65.2%)	57.5	81.6
Some problems	701	173	874 (16%)	18.8	9.9
Significant problems	880	148	1028 (18.8%)	23.6	8.5
Grand Total	3721	1743	5464	100.0	100.0

Source Kent Probation 2013

Table 31 Binge Drinking/Excessive Alcohol in last 6 months.

Of this 2012 cohort the majority stated that they had no problem with alcohol and some 16% had some problem whilst a sizeable proportion stated that they had significant problems. (See Table 31 above). Those on Licence expressed fewer problems as a percentage than those on community sentence. This may well reflect the formers recent stay in prison. It does however clearly reflect a need for alcohol based managed interventions for this group.

Likewise when viewing historic alcohol misuse (See Table 32 below) of those who chose to disclose their alcohol use, the level of the overall percentage of those with some and significant problems reflects the current status above. However when looking at the difference between the two groups, namely community sentences and those on licence, it is the latter group that has the higher prevalence of problems particularly significant problems. This again reinforces the need to have well managed and structured alcohol misuse support mechanisms in place.

Frequency / Level of Alcohol Misuse in Past	Community	Licence	Grand Total	Community %	Licence %
No problems	920	549	1469 (26.9%)	24.7	31.5
Some problems	582	283	865 (15.8%)	15.6	16.2
Significant problems	816	385	1201 (22%)	21.9	22.1
(blank)	1403	526	1929 (35.3%)	37.7	30.2
Grand Total	3721	1743	5464	100.0	100.0

Source Kent Probation 2013

Table 32 Frequency/level of Alcohol Misuse in Past

Looking at alcohol related violent behaviour again (See Table 33 below) for those whose disclosure is known a sizeable proportion can relate to this offending behaviour with little difference between community sentence offenders and licenced offenders.

Violent Behaviour Related to Alcohol Use	Community	Licence	Grand Total	Community %	Licence %
No	1275	718	1993 (36.5%)	34.3	41.2
Yes	1024	494	1518 (27.8%)	27.5	28.3
(blank)	1422	531	1953 (35.7%)	38.2	30.5
Grand Total	3721	1743	5464	100.0	100.0

Source Kent Probation 2013

Table 33 Violent Behaviour Related to Alcohol Use.

Motivation to Tackle Alcohol Misuse	Community	Licence	Grand Total	Community %	Licence %
No problems	1569	958	2527 (46.2%)	42.2	55.0
Some problems	601	204	805 (14.7%)	16.2	11.7
Significant problems	148	56	204 (3.7%)	4.0	3.2
(blank)	1403	525	1928 (35.3%)	37.7	30.1
Grand Total	3721	1743	5464	100.0	100.0

Source Kent Probation 2013

Table 34 Motivation to Tackle Alcohol Misuse.

For those who disclosed as having no problems to be motivated to tackle alcohol misuse it is approximately half of the offenders, although it should be noted that the records are not complete for a third of this group. There is however a noteworthy number of them who have problems and therefore requiring appropriate support and service access. Given that just over one third of the offender records on this issue were blank there is therefore a need to ensure that timely and accurate physical and mental health related data is entered onto the offender management system.

There are real opportunities for those who come into contact with community offenders to assist to identify those at risk and provide advice and support when needed, through evidenced brief interventions. Identification and Brief Advice (IBA) is a simple intervention aimed at individuals who are at risk through drinking above the guidelines. There is a strong case for further investment in IBAs including the relevant training of appropriate staff in the Probation setting.

Finally Commissioners should develop a joint working policy, procedure and care pathway for community offenders with mental health and alcohol misuse problems (significant co-morbidity with mental illness requires pathway development into alcohol / mental health dual diagnosis services). Referral tools and pathways already agreed by commissioners and providers should be used.

Drugs

Offenders tend to have much higher rates of drug use than the general population, Reducing Drug use, Reducing Reoffending identified that 10% of the UK household population had used drugs compared to 73% of new male prison entrants.

Substance misuse exists alongside one or more mental health disorders and over 85% of prisoners reported smoking, hazardous drinking or drug dependence in the year before coming into prison.

Drug abuse has serious implications for physical health. The South East Region Public Health Fact Sheet: Offender Health identifies that 24% of prisoners are injecting drug users, of whom 20% have Hepatitis B and 30% Hepatitis C.

Many substance misusers have multiple needs. In the Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) reported that 74.55 of drug service users also experienced mental health problems and that approximately 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Many substance misusers also suffer from multiple addictions with secondary alcohol addiction which makes treatment more complex.

Data from the National Treatment Agency for Substance Misuse (April 2011-March 2012) cites that the mean age of clients entering treatment was 35 and that 73% were male, and that most clients were White British (83%) whilst no other ethnic group accounted for more than 2%. The most common route for treatment was self-referral (40%) and 29% from the criminal justice system.

The cohort of offenders was invited to state whether they used any illegal substances and if so did they want to seek help? Of the 77 that answered 13 answered “yes” and 64 “no” with 22 no responses. This represents some 13% of the group in total or approximately 17% of those who responded. This figure would appear to be low as other studies show greater prevalence e.g. Hertfordshire 32% and Nottinghamshire/Derbyshire 38%.

Drugs	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
No	17	25	8	10	1	1	2	**64**
No Response	5	5	5	2	3		2	**22**
Yes	3	6	3	1				**13**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**12%**	**17%**	**19%**	**8%**	**0%**	**0%**	**0%**	**13%**

Table 35 Self-admitted use of illegal drugs by age band

(6 of the 13 offenders said that they would like help with their addiction)

Of interest is the fact that of those offenders using drugs 32% perceives their health as Good or better.

Self-Declared Health Status	Drugs	Drugs %
Excellent	2	14%
Very Good	1	4%
Good	4	14%
Fair	2	13%
Poor	4	29%
No response		0%
Total	**13**	**13%**

Table 36 Drug users self-declared health status.

Patiently there is a need to better understand the prevalence of drug misuse of this cohort by a more detailed study

OASys data was made available from Kent Probation for drug misuse.

Drugs Ever Misused in Custody/Community	Community	Licence	Grand Total
No	1351 (36%)	498 (29%)	1849 (34%)
Yes	2370 (44%)	1245 (71%)	3615 (66%)
Grand Total	3721 (100%)	1743 (100%)	5464 (100)

Main Drug Usage Level	Community	Licence	Grand Total
Less than weekly	1069	714	1783
At least weekly	580	201	781
Missing	2072	828	2900
Grand Total	3721	1743	5464

Source: Kent Probation 2013

Table 37 Drug Misuse in the Community & Custody – Offender Disclosure

44% of offenders on community orders, compared to 52% released on licence during 2011-12 misused drugs with 30% of all these offenders using their main drug at least weekly.

Ever Injected Drugs	Community	Licence	Grand Total
Never	1377 (84%)	756 (83%)	2133
Previously	165 (10%)	138 (15%)	303
Currently	107 (6%)	21 (2%)	128
Missing	2072 (56%)	828 (48%)	2900 (53%)
Grand Total	3721	1743	5464

Source: Kent Probation 2013

Table 38 Have you ever injected drugs – Offender Disclosure

Of the community offenders whose current status is known some 84% have never injected drugs and of the remaining community offenders 10% have previously injected and 6% are currently injecting. With those on licence whose current status is known some 83% have never injected and of those remaining 15% have previously injected and 2% are currently doing so.
There is however a significant number whose status is unknown – overall 53% with a higher percentage absent in the community offender group.

Motivation to Tackle Drug Misuse	Community	Licence	Grand Total
No problems	1420 (61%)	880 (71%)	2300
Some problems	704 (31%)	295 (24%)	999
Significant problems	246 (8%)	70 (5%)	316
(blank)	1351 (36%)	498 (29%)	1849
Grand Total	3721	1743	5464

Source: Kent Probation 2013

Table 39 Motivation to tackle Drug Misuse – Offender Disclosure

Again there is a significant proportion (36%) of offenders serving a community sentence whose motivational status is unknown; of those whose status is known a large proportion state that they have no problems. Almost 1000 offenders have some or significant problem in addressing their drug misuse problem. There are smaller proportions of those on Licence whose status is unknown (29%) but still one which is sizeable and for those with a problem addressing their habit again the proportions are smaller.

The relevant Commissioner from Kent Probation meets regularly with service managers from the service providers Turning Point for East Kent, CRI for West Kent & KCA for Medway. There are also multi agency meetings between the Kent Probation Substance Misuse Commissioner, local lead practitioners, provider staff, Police DLOs and KCC, so Kent Probation believe that relationships to be generally close.

Quarterly 'multi-agency' meetings are held between senior provider staff, Kent Police DLOs and Kent Probation lead practitioners for all 3 services at which they look at Probation's internal DRR & ATR i.e. Requirement Start & Completion figures but this is not a formal contract performance review meeting with providers as the contracts are managed by KCC & Medway Council who have their own reporting processes

There is a Kent and Medway Serious Incident Panel (SIP). The SIP is held quarterly and the last panel was held on the 7th November 2013. The latest SIP report covers deaths that occurred between April and June 2013 in Kent and Medway. The format of this report has changed over time and they have not undertaken any specific analysis around offender deaths in the past but this is something that they can include as a matter of course in their next report. The police analyst produces an annual report and they state that they will ensure that they will provide an analysis on offender deaths. They will also incorporate this as part of their Needs Assessment which is currently work in progress.

With regards to the November report there were a number of offender deaths:

1 (Kent): on a DRR
2 (Medway): on an ATR
3 (Kent) – finished DRR and then self-referred to substance misuse treatment
4 (Kent) – was released from HMP Lewes
5 (Medway) – on a ATR
6 (Medway) – previous probation involvement

One of the findings from this report is the requirement for a more consistent review process for those not complying with DRR orders. This will be reported to the Kent and Medway Criminal Justice Forum.

Illicit drug misuse among adults (16 to 59 years) in England and Wales declined in 2012/13 to 8.2%, of which the South East region was the third highest, around 8.4%. Applying the current South East figure is to the Kent population results in over 67,000 people having used drugs at least once in the last year (5.8% - Kent JSNA 2013).

Other Health Related Areas

Sexual Health

	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
No	3	3	4	1				**11**
No Response	5	9	4	2	2		3	**25**
Yes	17	24	8	10	2	1	1	**63**
Total	**25**	**36**	**16**	**13**	**4**	**1**	**4**	**99**
Yes %	**68%**	**67%**	**50%**	**77%**	**50%**	**100%**	**25%**	**64%**

Table 40 Do you know where to go for help on sexual health?

Health Protection

Vaccinations	19-24 (n=25)	25-34 (n=36)	35-44 (n=16)	45-54 (n=13)	55-64 (n=4)	65+ (n=1)	No response	Grand Total
MMR (number)	9	14	4	4				31
MMR (%)	36%	39%	25%	31%	0%	0%	0%	31%
Hep B (number)	9	16	4	5				34
Hep B (%)	36%	44%	25%	38%	0%	0%	0%	34%
Hep C (number)	8	12	4	3				27
Hep C (%)	32%	33%	25%	23%	0%	0%	0%	27%
All 3 Vaccinations	6	6	3	2				
All 3 Vaccinations (%)	24%	17%	19%	15%	0%	0%	0%	0%

Table 41 Uptake of vaccinations amongst offenders

GP and Dentist Registration

Self-Declared Health Status	Registered with a Doctor	% Registered with a Doctor	Registered with a Dentist	% Registered with a Dentist
Excellent	7	50%	5	36%
Very Good	17	65%	17	65%
Good	21	75%	10	36%
Fair	12	75%	6	38%
Poor	9	64%	5	36%
No response		0%		0%
Total	66	67%	43	43%

Table 42 Offenders registered with a doctor or dentist

These totals of GP and Dentist registration (67% & 43%) compare with 91% and 50% respectively for the Hertfordshire Probation Trust area. (Kent CC area population 96%)
The Kent Probation NDelius system determined that on the 31/03/2013, 1059 offenders in Kent had a Doctor or Local GP as a recorded associated professional contact that is approximately 25% of the cohort size.

Other Services (wider determinants)

Other Services Accessed	19-24	25-34	35-44	45-54	55-64	65+	No response	Grand Total
Housing	1	8	6	5	1			21
Housing (%)	4%	22%	38%	38%	25%	0%	0%	21%
Training	1	8	2	2			1	14
Training (%)	4%	22%	13%	15%	0%	0%	25%	14%
Employment	5	7	1	6				19
Employment (%)	20%	19%	6%	46%	0%	0%	0%	19%
Finances		2	1					3
Finances (%)	0%	6%	6%	0%	0%	0%	0%	3%

Table 43 Assistance in accessing Services by Offenders (n=37)

Comparison table

Condition/Lifestyle	Kent Probation	Herts Probation	Nottinghamshire & Derbyshire Probation	HMP Elmley	K & M Custody
	%	%	%	%	%
Disability	11	NA	NA	<1	NA
Asthma	18	15	NA	6	NA
Diabetes	4	2	NA	2.3	NA
Heart/circulatory	9	NA	NA	1.5	NA
MH	50	28	27	NA	8.2
Other	20	NA	NA	NA	NA
Smoke	>53	78	83	74	NA
Alcohol	43	67	43	48	38
Drugs	66	33	33*	41	38
Gender split	86/14	85/15	82/18	100	86/14
GP registration	67	91	80	-	-
Dentist registration	43	50	55	-	-
*Nottinghamshire & Derbyshire Probation OASys data 62.8% Drug use					

Table 44 Comparison table with other areas/places

Health Trainer Service – Kent CC Area and Medway Area

It is a strategic objective of the Kent and Medway Reducing Reoffending Board that all offenders within IOM have access to a Health Trainer.

In Kent the Health Trainer Service is commissioned by Kent County Council Public Health and provided by Kent Community Health NHS Trust. Health Trainer offer free, confidential one-to-one support, to help patients make positive lifestyle changes. Whilst they work in the most deprived areas of Kent to reduce health inequalities they are also present at 6 Kent probation local offices:-

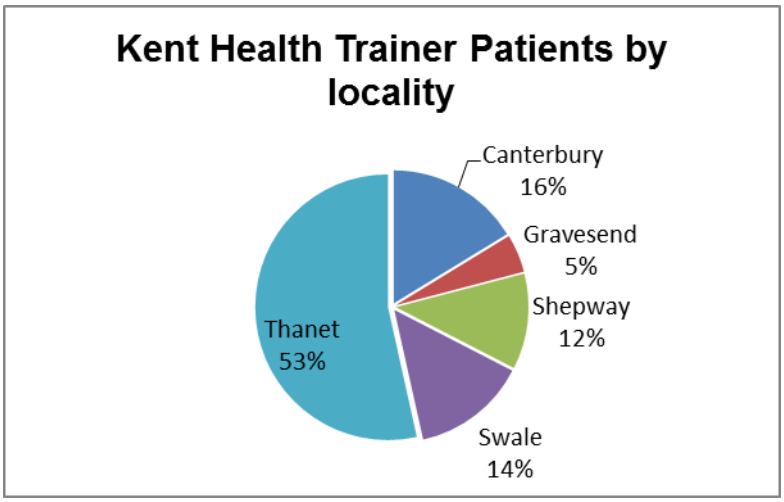
- Canterbury - 6 hours per week. Commenced April 2013
- Gravesend - 7.5 hours per week. Commenced 2013
- Maidstone – arrangements currently in progress (December 2013)
- Shepway – 11.5 hours per week. Commenced in 2011
- Swale – 7.5 hours per week. Commenced in December 2011
- Thanet – 15 hours per week. Commenced in 2010

They offer up to six free sessions of support, encouragement and practical assistance at these local venues and work with patients to establish changes they wish to make, to develop a personalised behaviour change plan and to provide support and encouragement to enable them to achieve their goals.

Issues the Health Trainers Service can help offenders with include: - accessing local services - physical activity - healthy eating - healthy weight - stopping smoking - alcohol/drugs concerns - reducing stress - sexual health concerns.

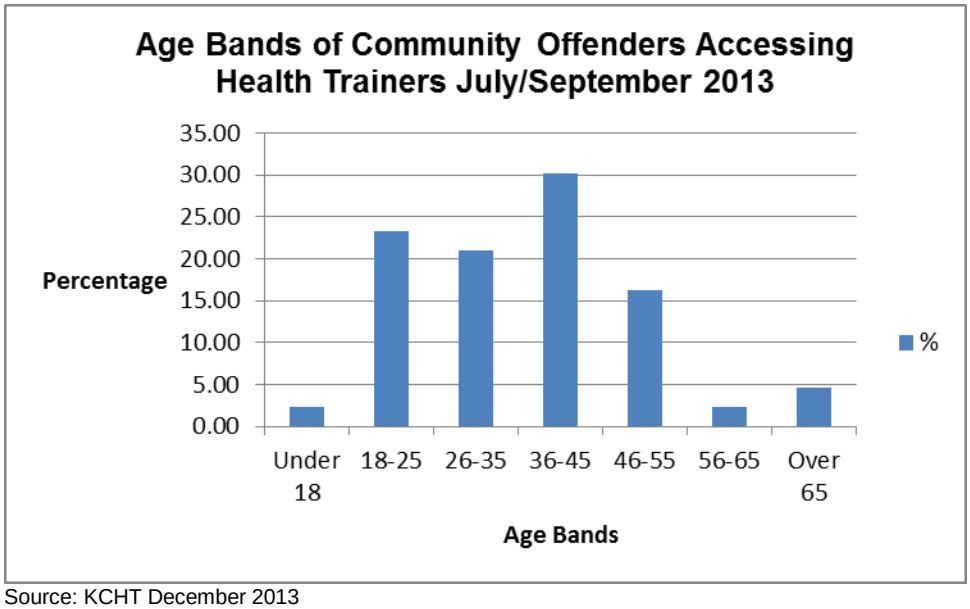
In the three months July to September 2013 they current 5 locality services worked with 43 new patients on a variety of health related areas including exercise 27%, emotional wellbeing 20%, diet and GP /Dentist registration both 13%, smoking 6% , mental health 3% and other matters. Of the 43 attendees 37 were male (86%) and 6 female (14%).

The Health Trainer Service recognise that the numbers could be higher so it is intended that an experienced Health Trainer from the Thanet office is to share his experience with other Health Trainers working at Kent Probation offices during the early part of 2014 to help increase the number of offenders who access the service. Evidence from other areas in England where similar schemes based upon Health Trainers are in place shows that it is an effective service which enables this group to make significant changes in their lifestyle and improve their social capital.



Source: KCHT December 2013

Chart 18 Kent Health Trainer Patient numbers as a percentage by locality



Source: KCHT December 2013

Table 45 Age bands of Community Offenders Accessing Kent Health Trainers July – September 2013.

In Medway the Health Trainer Service is commissioned by Medway Unitary Council and provided by Sunlight Development Trust HALT. Health Trainer offer free, confidential one-to-one support, to help patients make positive lifestyle changes. Whilst they work in the most deprived areas of Medway to reduce health inequalities they are also present at the one probation local office.

Medway Probation Clients Progress Report June 2013

In the period July 2012- June 2013 HALT 25 new clients attended an assessment with the Health Trainer based at the Probation Service. The chart below shows the distribution of assessments over the year.
DNA rate is high amongst this client group. Some 151 appointments were made by the Probation Service however of these 72 were DNA's (48%), a significantly higher rate than average for HALT

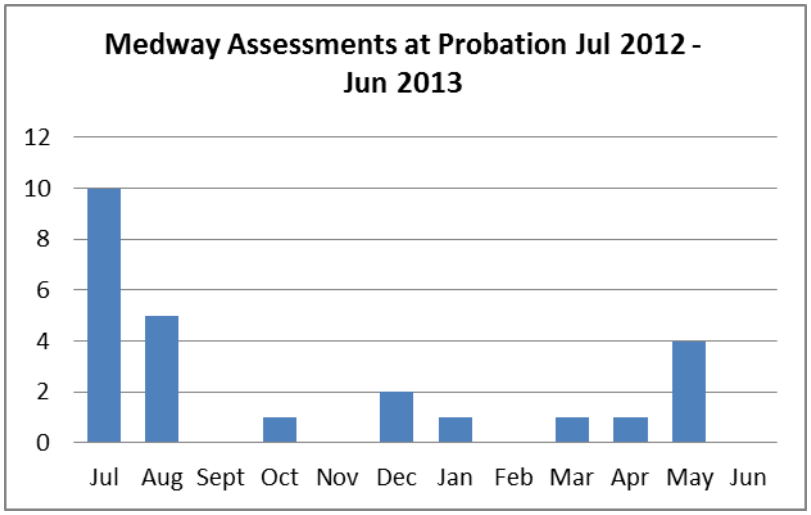
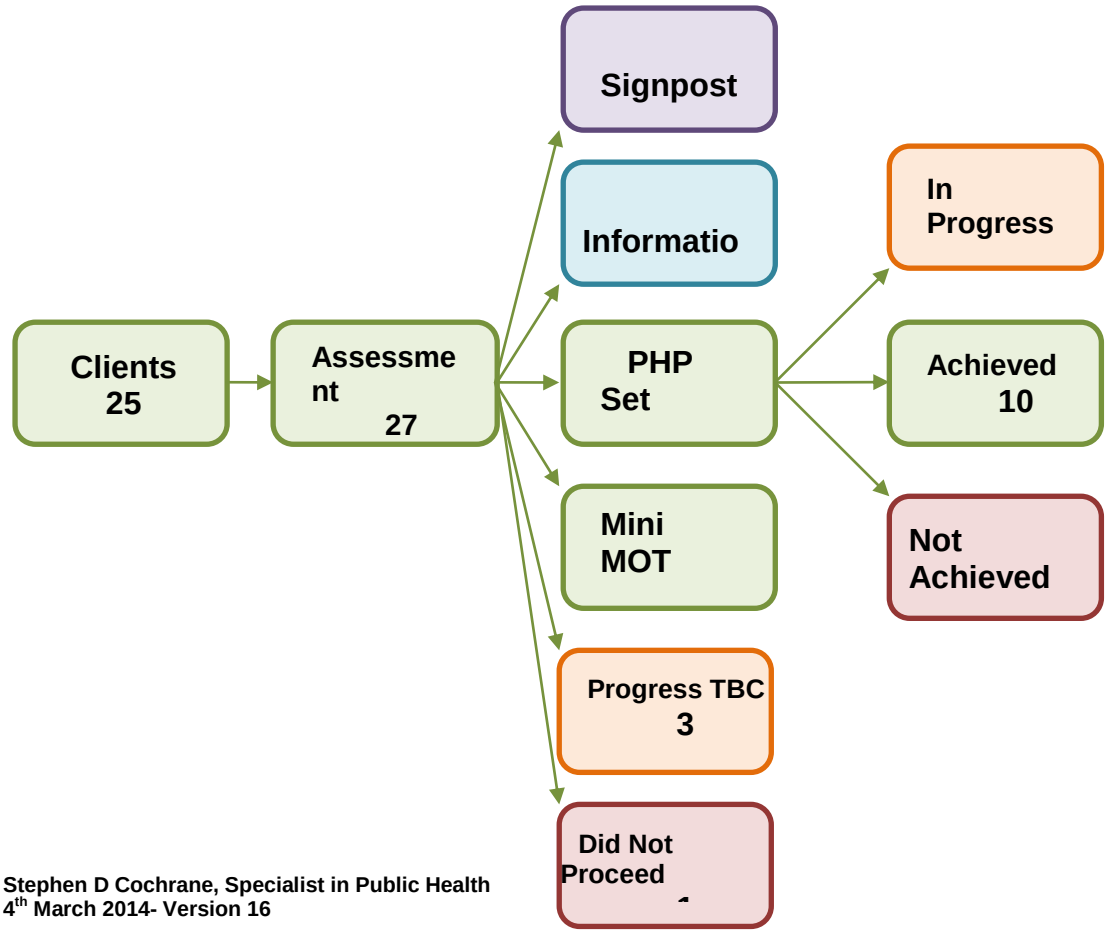


Chart 19 Medway Assessments at Probation July 2012 - June 2013

The diagram below shows the client progress to date.



Medway Client Demographics

88% of clients from the Probation Service were male. 56% were aged 18-35.

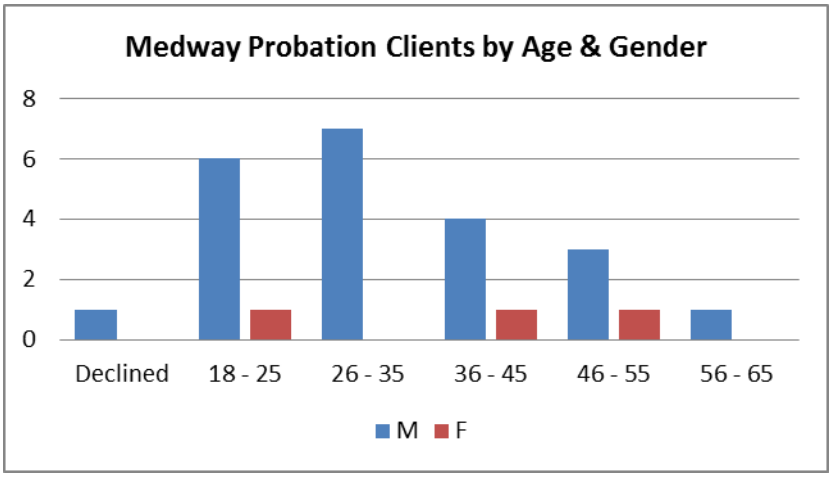


Chart 20 Medway Probation Clients by Age & Gender

76% of clients live in Medway wards of deprivation (deprivation quintiles 1 and 2).

	Declined	18 - 25	26 - 35	36 - 45	46 - 55	56 - 65	Total
Male	1	6	7	4	3	1	**22**
Female	0	1	0	1	1	0	**3**
Total	**1**	**7**	**7**	**5**	**4**	**1**	**25**

Table 46 Age bands & Gender of Community Offenders Accessing Medway Health Trainers

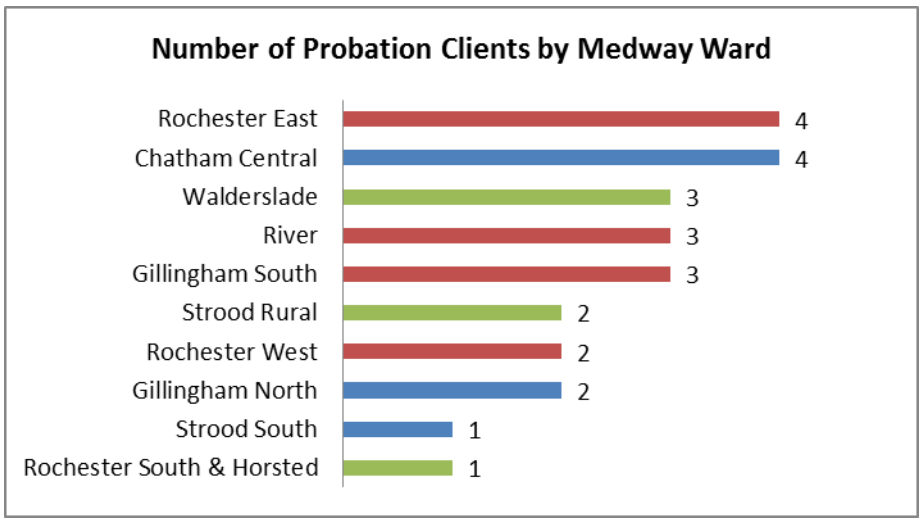


Chart 21 Number of Probation Clients by Medway Ward

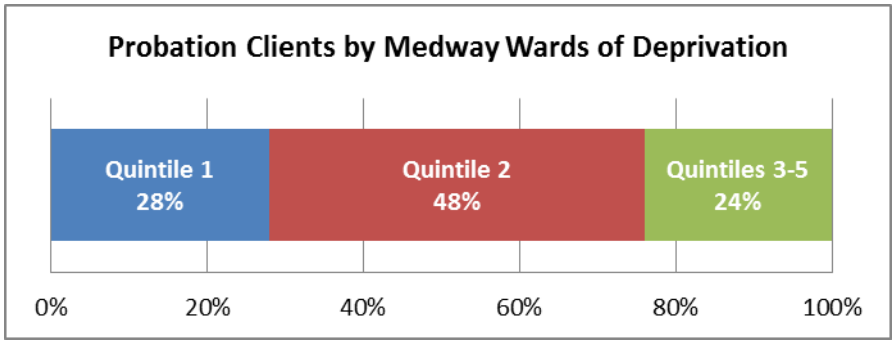


Chart 22 Probation Clients by Medway Wards of Deprivation

Outcomes

Signpost

1 client was signed off after a signpost to a dentist who was registering NHS patients.

Information Only

1 client was signed off after being given British Heart Foundation resources to consider lifestyle changes he could make.

Mini MOT

5 clients opted for a Mini MOT. This involved completing a lifestyle questionairre covering diet, exercise, smoking, alcohol and emotional wellbeing and discussing areas for improvement with the Health Trainer. The clients were then given information to take away and consider.

Personal Health Plans

16 PHPs have been set. The issues addressed are shown below.

PHP Issues	Achieved	Not Achieved	In Progress	Total
Diet	3	1	1	5
Exercise	1	0	2	3
Smoking	3	1	1	5
GP Registration	3	0	0	3
Total	**10**	**2**	**4**	**16**

Table 47 Personal Health Plans Achievement Medway

12 PHPs have been completed. 10 (83%) were achieved. The success rate for each issue is shown below.

PHP Issues	Achieved	Not Achieved	Total	Achievement Rate
Diet	3	1	4	**75%**
Exercise	1	0	1	**100%**
Smoking	3	1	4	**75%**
GP Registration	3	0	3	**100%**
Total	**10**	**2**	**12**	**83%**

Table 48 Personal Health Plans Achievement Rates Medway

Referrals

During PHPs it often comes apparent that clients could benefit from other services alongside a Health Trainer. As well as signposting Passport to Leisure, dentists, exercise classes and social groups, the Health Trainer referred 2 clients to Exercise Referral and 1 client to a counselling service.

Absentees Medical Reason

As part of the offender management process, offenders have to present themselves at a relevant locality Kent probation OMU. Failure to attend, whether approved or not is recorded along with an appropriate reason. Failure to comply with this attendance requirement invokes certain management actions which have implications for the offender.

Approved medical reasons for an absence were analysed for the period 1st January 2013 to 31st December 2013 to assess whether there were any particular issues or trends which were noticeable. There were 61,741 recorded attendance appointments which related to a 3799 individual offenders – 16.27 attendance appointments per offender. The number of offenders who complied with their requirement to attend was 69.6% with the remaining 30.4% not attending for a variety of reasons. (See Table 49 below). However of this only 1.6% of all the scheduled occasions related to an acceptable absence for medical reasons. It is important to note that attendance at a Provider Service as a result of a Community Sentence requirement is an acceptable medical absence.

Table 49 Outcomes of offender attendance, percentage, 2013

	Total scheduled occasions	Percentage of all scheduled occasions
Attended - Complied	43020	69.6%
Acceptable Absence - Other	3052	4.9%
Failed to Attend	2274	3.7%
Unacceptable Absence	3309	5.4%
Acceptable Absence-Professional Judgement Decision	1263	2.0%
Rescheduled - Offender Request	1613	2.6%
Acceptable Absence - Medical	986	1.6%
Acceptable Absence - Employment	503	0.8%
Rescheduled - Service Request	645	1.0%
Suspended	697	1.1%
Other reasons	1595	2.6%
Not recorded reason	2874	4.6%
All occasions	61741	100.0%

Source: Kent Probation 2014

Offenders not attending for medical reasons for medical reasons on all occasions in 2013 numbered some separate 527 offenders which represent 13.9% of the 3799 offenders in this data set. The majority of these absences were from 1 – 3 days, with few occasions of more than 7 days. (See Table 50 below)

Table 50 Offenders not attending for medical reasons, on all occasions 2013

	Absence for medical reasons (persons)	Percentage of offenders
1-3 days	471	12.4%
4-7 days	37	1.0%
more than 7 days	19	0.5%
Total all occasions	527	13.9%
Total number of offenders	3799	100.0%

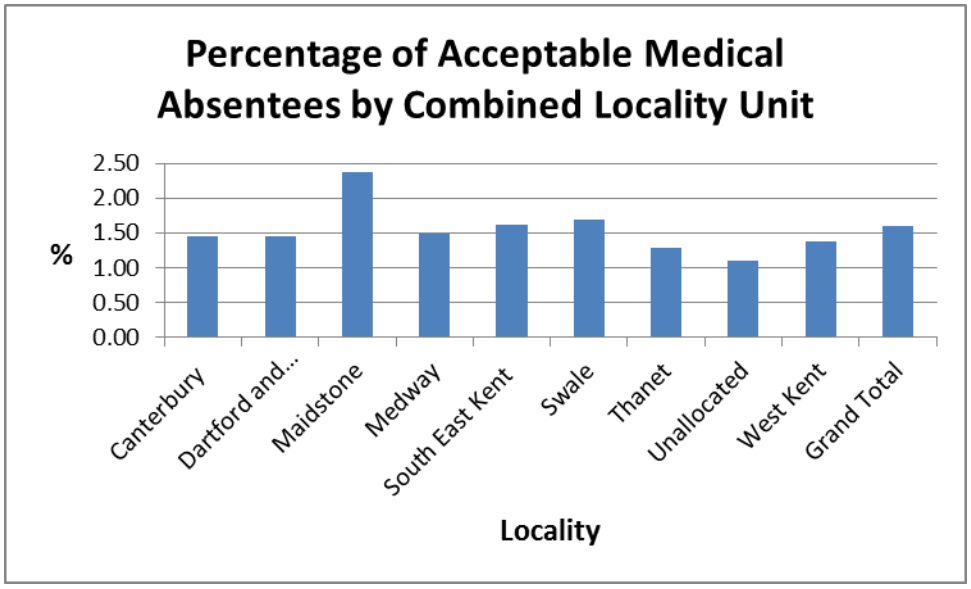
In terms of locality performance there is little difference between the locality OMU except Maidstone is the locality with the highest percentage with the Maidstone Community Payback unit showing the largest percentage (2.6%) and the Thanet CP unit the lowest (0.9%).

Table 51: Proportion of medical absence as all occasions outcomes by teams

	Acceptable absence medical	All attendance outcomes	Percentage medical absence - team
Canterbury CP	19	1302	1.5%
Canterbury OMU	54	3755	1.4%
Dartford and Gravesham CP	50	2430	2.1%
Dartford and Gravesham OMU	41	3827	1.1%
Maidstone CP	27	1039	2.6%
Maidstone OMU	151	6475	2.3%
Medway CP	59	4323	1.4%
Medway OMU	124	7931	1.6%
South East Kent CP	33	2901	1.1%
South East Kent OMU	147	8267	1.8%
Swale CP	21	1352	1.6%
Swale OMU	79	4547	1.7%
Thanet CP	18	1918	0.9%
Thanet OMU	72	5078	1.4%
Unallocated	1	91	1.1%
West Kent CP	32	1892	1.7%
West Kent OMU	58	4613	1.3%
Grand Total	986	61741	1.6%

Source: Kent Probation 2014.

Chart 23 Percentage of Acceptable Medical Absentees by Combined Locality Unit



No data was available regarding the medical diagnosis for the absence and whether the absence was either self-certificated or approved by a GP. This aspect should be developed.

Discussion

Frequently in Health Needs Assessments which assess the needs of various cohorts in the criminal justice system, the assessment process is frustrated by many factors which can include a paucity of data, data that is incomplete, failure by patients/clients to disclose their status and erroneous disclosure. This Health Needs Assessment is no exception and to a large extent the process has had to rely upon the triangulation of the available data with that from other relevant studies both regional and national. To express health needs correctly commissioners cannot be reliant upon imprecise and incomplete data.

The results from the Health and well-being Survey although few in number given the size of the total population throws some light on the community offender health and well-being status and bears some comparison with other such surveys. It was disappointing that the engagement with and by the community offenders was low which probably reflects the decision to change the original methodology and manage the survey alongside the annual Kent Probation 2012 user survey.

The OASys data is more robust in terms of quantity but again there are significant gaps in knowledge of offender disclosure regarding both their mental health and substance misuse status. Clearly however the prevalence rates are more in keeping with known rates published in this offending population.

A significant proportion of those offenders completing their sentence in the community were subject to licence conditions post release from prison and this group should therefore reflect the general morbidity of the prison population. To complete the picture it would have been helpful to have understood the previous prison history of the remaining probation population to complete the picture of morbidity but unfortunately this data was not available. However this offender population is known for their “revolving door” status in and out of prison so in broad terms prison inmate morbidity may well be the norm.

Many of these offenders exist in a troubled and chaotic lifestyle which is a reflection of not only of their mental health status but also their substance misuse habit. Evidence from the Kent Probation Substance Misuse Commissioner and the service Providers echoes that of the offenders in that how to access the service is known, is used and valued by them. This though did not appear to be sustained in terms of mental health with offenders often stating that to access community services was both difficult and problematic. However the availability of mental health counselling and the innovative Personality Disorder project may well prove to help the situation. There is nevertheless a need in the proposed community offender management structure under “Reducing Reoffending” for the Criminal Justice Mental Health Service Commissioner(s) to ensure that the pathway is integrated to deliver seamless service from the Kent and Medway designated resettlement prisons back into the community. Community offenders should benefit from such arrangements.

Research has shown that the Health Trainer service in a Probation setting can deliver valuable lifestyle improvements for community offenders. Whilst there is a basic service in place better structured and supported health leadership from those both commissioning and providing the service would enhance the development and capacity. There is also a real need to develop public health leadership in the new offender management structure both at the Regional National Probation Service and CRC levels. Both Kent County Council and Medway Council Public Health have a pivotal role in this development through the Public Health Champion programme and should actively promote this with all the emerging organisations as well as within the wider Criminal Justice system as part of the non-statutory partnership arrangements around “Reducing Reoffending”

The rate of success or failure in improving the health and wellbeing status of all these community offenders is somewhat obscure in that all the data relating to the commissioned community health related services are either not recorded or where they are, they are never collectively managed with other information to ensure that appropriate improvement trajectories are visible and a truly integrated approach taken. The challenge is to discover innovative ways for the different partners to engage collectively with offenders in the criminal justice system towards common health improvement and protection goals.

This could be secured with better overview and scrutiny arrangements being in place and could take the form of a Health and Wellbeing Group reporting to the locality Reoffending Board. Its operating model could be based upon that used in the prison setting "Health Promoting Prisons – A Shared Approach" (Department of Health 2002). This set the foundations for the introduction of a Prison Service Order (PSO 3200) on health promotion in 2003 (HM Prison Service 2003).Whilst historically there have been critics of this prison wide approach, if it were to be applied in a community/probation setting it would, it is argued fit more comfortably with the Bradley Report on offenders with mental health problems or learning disabilities, which highlighted the value of a whole criminal justice system approach that is from resettlement prison into the community. Given this base in the community it would not be in danger of obscuring the wider political, social and environmental determinants that can impinge upon offenders' health, such as poverty, education, employment and housing. A governance framework for this Group is shown in Appendix 2.

Public health's important stewardship function can support criminal justice institutions and their partner agencies to develop this system-wide health improvement and social development, potentially leading to longer term reductions in inequalities. Whilst there is currently Consultant level involvement at the strategic reducing reoffending Board level there is a need for public health operational leadership in the interim until such time as the Public Health Champion programme bore fruit. This could take the form of Specialist involvement to develop the integration of health improvement and protection with the associated multi agency network so as to provide a hardy framework to carry the work forward, setting levels of ambition and developing local targets.

There is still however still much to be done to increase not only the profile and status of health improvement with community offenders but also actual visible and measurable improvement in their health status and engaging with local physical and mental health services. GP registration, smoking cessation and similar based services need to evidence better success and it is incumbent on commissioners to develop strategies to enable their providers to strengthen success to ensure that community offenders are able to actualise an appreciation of their health and its importance in their road to managing their lifestyle and therefore reducing their offending habits.

Stakeholder Consultations and Engagement

In order to better understand the health needs and service experiences of Community Offenders qualitative research was undertaken with Offenders, Probation Officers, GPs and Health Trainers. The geographical areas that were targeted were deemed to be those with greatest concentrations of Offenders with health needs:

- Canterbury
- Chatham
- Folkestone
- Medway
- Thanet.

Methodology

An independent researcher was commissioned to undertake the research which took place between November 2012 and February 2013. The findings have been analysed and emerging themes that cover health conditions, lifestyle and service delivery have been used to present the findings. Where relevant to help set the context published research, guidance or policy is quoted. Case studies are used to illustrate the main points – some of these cover a range of issues and have been placed where they illustrate a main point.

Community Offenders

The Probation Service worked hard to promote the HNA research with Community Offenders and managed the administration and recruitment process. Fourteen individuals (all but one being at high risk of re-offending) were identified by their Probation Officers as having significant health needs or having had experiences of health services that would be of interest to the HNA. They all agreed to be interviewed in person although two were interviewed over the telephone due to diary clashes. Four did not attend on the day – hence a total of ten in-depth interviews were undertaken.

An interview template was adapted from the Questionnaire used for the survey (Appendix 1) in order to maintain consistency across the HNA and help build the evidence base. Following the interview a case study was written and sent back to the interviewee for their approval. This was seen as important in building trust and respect on both sides. Most agreed with what had been written and case studies were amended slightly.

Of those interviewed there were nine men and one woman which reflect the gender balance in the Offender Population. All but two had a long history of being in and out of Prison; two stated a determination to stay out of trouble. Most were aged between early twenty and sixty years old with one in his seventies. All self-classified their ethnicity as 'White British'. Most rated their health as 'good' with the exception of all four people from Folkestone who rated their health as poor or fair (this might be due to the selection process in this area.)

Feedback from this process suggests that including the views of the offenders in a targeted manner was valued by them *'Thank you very much, the experience was very uplifting for CSX, he felt as if he had been heard for the first time.*' (Probation Officer).

Probation Officers

The views of Probation Officers were sought through offers to attend team meetings and written feedback. It was only possible to attend one meeting as the team meetings were very busy. A number of Probation Officers added written or verbal feedback when liaising about the Community Offender case studies. The feedback received is valuable and adds a further perspective to the health needs of Community Offenders.

GPs and Health Trainers

Two GPs volunteered to contribute their experiences and suggestions in telephone interviews. Health trainer's views were submitted by their manager.

General Health and Lifestyle Findings

General health lifestyle: Findings from Community Offenders
All had heard of 'five a day', most reported eating 1-2 portions of fruit and vegetables. However, Probation Officers reported that being able or interested in maintaining a healthy diet was not a priority for most Offenders.

Most did some form of exercise such as walking and half of them had used the gym whilst in prison and continued in the community. Although they noted cost and time was more of a barrier when in the community. However they also noted that using the gym made them feel good about themselves and helped with 'anger management.'

All but two stated they 'knew' where to go for Sexual Health' services and some were keen to say they had had STDs but were now taking precautions. The one who did not know wanted to know how to get a 'Condom Card' – this information was given to him

All had had hepatitis B and C checks and vaccinations where applicable whilst they were in prison. None knew if they had had an MMR vaccination.

Smoking rates were high, and drug and alcohol use patterns are covered specifically in later section.

Summary These findings are consistent with those from the wider survey work reported in the previous chapter. However, there was an opportunity to explore in some more detail the lifestyle issues. It was clear that Community Offenders were aware of healthy lifestyle messages and knew where to go for support. However, following up on this was not a priority for many as they felt they had more pressing concerns such as housing and staying 'out of trouble'. Probation Officers reported that they noticed a lack of motivation in Community Offenders, particularly in those with a more 'chaotic' lifestyle, to respond the adopting more healthy lifestyles despite their having the knowledge.

Specific health conditions

Specific health: Findings from Community Offenders
Many of those interviewed were very clear and open about their health needs and concerns. It was striking how much insight they expressed about their own responsibility in managing their conditions *"People have got to be motivated to do things for themselves and not expect others to do it for them"* and the problems they sometimes had in doing this. Reasons given for this included when they were in under stress or in a chaotic stage of their lives they were less motivated to take care of themselves or when external factors made it more challenging such as problems with housing. Managing their health becomes less of a priority than survival.

Some of those interviewed had a physical health illness and one had a range of complex health needs. Health conditions reported were Diabetes, Asthma, a blood disorder, two had Coronary Heart Disease.

Case study CS6 is a 49 year old male who has been in and out of prison. He has diet controlled Diabetes and has problems with the circulation in his legs due to his injecting drug use. He has been a Heroin user and is currently undergoing treatment for his addiction. He has been homeless since his last discharge from prison two months ago.

CS6 was referred to see an NHS Consultant in a local hospital whilst in prison. He was recommended surgery to improve the circulation in his legs as he now has ulcers which require regular dressings.

CS6 reports that since his discharge from prison he has not had a fixed address and the letter from the hospital with his surgery date has not been able to reach him. He feels anxious about this as he is worried about the circulation in his legs, plus his poor health is reducing his chances of work and his motivation for staying off drugs.

Case study CS9 is a 76 year old male who lives alone. He has a history of a range of on-going, and in some areas degenerating, health problems having been a fit man for most of his adult life. He has held a responsible job in the past but has since been in Prison which he claims to be 'ashamed of'.

He has Coronary Heart Disease, respiratory problems, hearing problems and Rheumatoid Arthritis – the latter having been exacerbated by Polymyalgia which is severely hampering his mobility – he walks with sticks. In addition, a year ago he was assessed and diagnosed with Alzheimer's.

Asked what would make a difference CS9 suggests that having one Support Worker who can liaise with all the services and help him understand what is being offered and able to access them.

Summary: Managing independent living with specific and complex medical conditions can be challenging at the best of times. The first case study demonstrates how hard it can be to follow up Community Offenders on discharge from prison particularly if they have no fixed address. It was felt by those interviewed that there did not appear to be good communication between Prison Health Services and those in the community. See latter section on GPs and Locums.

Probation Officers and GPs felt that there was not enough joint communication and working between health and Probation services.

Mental health including personality disorder

Offenders have a high prevalence of many health problems, particularly mental illness and substance misuse. Passage through the various elements of the criminal justice system (CJS) provides both the potential for initial access to healthcare and also the disruption of existing care.

The COCOA (Care for Offenders: Continuity of Access) research study shows that support for offenders with mental health problems 'falls substantially short of the treatment available for those with addictions.' Offenders reported low levels of health care contact for common mental health problems and comparatively high levels of contact with specialist drug services, particularly those using heroin. Analysis of the interview data used in the COCOA research showed that offenders contributed to low take-up of care by not always understanding how accessing healthcare could support their housing, employment and relationship goals.

‘It is not enough simply to divert individuals with mental health needs to mental health services. We need to work with offenders under prison or probation supervision to help them to take steps to improve their health alongside support for housing, employment and relationship needs.’ [i]

For some individuals personality disorder contributes significantly to their offending. Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder and a high proportion of cases are managed by probation. For a relatively small number of offenders, in its most severe forms, personality disorder is linked to a serious risk of harm to themselves and to others. These offenders have highly complex psychological needs that create challenges in terms of management, treatment and maintaining a safe working environment.[ii]

Mental Health: Findings from Community Offenders

Seven out the ten interviewed for the Kent Community Offenders HNA stated they had Mental Health problems – Anxiety, Depression and other specific diagnosis such as Personality Disorders with two people. However, most scored well on the ‘Emotional well-being’ question related to motivation and ability to get things done with only three people saying their condition had affected their well-being.

Case study CS1 is in her early 30s living in Kent for the last six years after being in London. She lives with the father of their three children under 7 years. She has a complex history of drug taking, serious mental health problems which have, on occasion required in-patient treatment as she self-harms, and has been in and out of the prison system all her adult life. She has recently been discharged from prison with a letter for her GP recommending that she is treated with Counselling, Psycho-therapy and is seen by the Community Psychiatric Nursing team.

She saw a locum GP who referred her for Counselling. However she has now been told that this request has been rejected by the NHS as her case ‘does not meet the funding criteria’. She reports that no other help has been offered and does not know how else to ‘get into the system’.

CS1 was distraught as feels she *‘has hit a brick wall. It’s my kids who are keeping me stable – if I didn’t have them I don’t know what I’d do’*. When in prison CS1 feels *“you get the help you need and I’ve not always taken advantage of this”.* Now she is ‘asking for help and feel I’m not being listened to and labelled as a junkie.’

Case study CS7 is a 52 year old male who has experienced Depression and Mental Health problems since he was a teenager. He has been on medication for the last 11 years. He has had Counselling over the years, however did not pursue the mental health services given his past experience with them of attending and being told to "*just keep taking his medication and not having any offer of further support".*
CS7 recently began to feel he was becoming depressed again. He overdosed on Alcohol and medication and was taken to hospital. He was seen by a psychiatrist for an assessment and has been waiting five weeks for a follow up appointment. He attends an Alcohol Support Group from time to time.

His GP has been supportive and encouraging him to 'stick with it'. Feels he has been treated well but it seems to 'take forever' once in the system to get help. He finds that when he is depressed it is hard to find the motivation to seek help and access help. It does help to 'know the system'. He feels safe at home and finds it hard to make himself go out when he feels depressed.

He speaks highly of the support he has had from the Probation service and observed "*can access services better through Probation than when not in trouble".*

Case study ten
CS10 is a 24 year old man who has been involved with the Mental Health system and on medication since he was 15 years old; and first went to Prison when he was 18 years old. His problems began with the death of his Grandmother when he became distressed and unable to cope with this loss, and started drinking Alcohol. He was offered some Bereavement Counselling and had a Young People's Mental Health worker. However, he found the Counselling in-effective as it was short term and he felt he needed time to build up trust with the Counsellor in order to open up about his problems.

When he reached 16 years old he was told he was too old for those services and he was too young for the Adult Mental Health system and was thus not having any specialist support. He used Alcohol as his way of escape and began petty crime to fund his Alcohol use. By the time he was 18 years old he was sent to Prison. He has since been in and out of Prison on a number of occasions, and allocated different Support Workers on each release.

On a number of occasions he has been discharged from Prison without somewhere to live and hence has been classified as Homeless. This has meant that CS10 has had to 'sofa-surf' at friends constantly moving from place to place, or having to stay at his Mother's on her sofa. He feels emotionally 'unstable' most of the time and feels he needs to remain close to the area where his Mother is living. He has been offered Hostel accommodation but not in the area, and one nearer the area which was not able to take him as his needs were too complex for them. In addition, this lack of permanent housing makes it difficult for health and other services to keep track of his fixed address and send appointments and follow him up.

When in Prison he feels more stable as he doesn't have to worry about a roof over his head, he has no access to Alcohol and can go to the gym to relieve his stress. It is when he is discharged that his problems seem to become more difficult to manage.

CS10 has had increasingly chaotic Mental Health problems – he reports that he was recently diagnosed with Emotional Personality Disorder and feels he has been passed from one service to another. He reports that they have not been able to give him a consistent worker or treatment pathway. Indeed he and his Mother were able to report many instances where he has become severally anxious and has not been able to get help from Mental Health services at the time that he needs them. He recalls a number of instances, some of them extreme, where he has put himself into a position of safety risk, in order to attract attention

from the Police as a way of highlighting his distress and as a way into emergency Mental Health Treatment. However, these incidents have ended with him being sent to Prison rather than a Mental Health Service.

There were also examples, which both he and his Mother recall where he was told that he was being given a place on a treatment programme but that offer was not followed up or it was withdrawn. They tried to have him placed with a specialist treatment provision in Kent but were told he didn't qualify as it is out of his catchment area.

He and his Mother are desperate for CS10 to be given access to consistent support worker, and talking therapies over a longer period of time where he has a chance to build trust and deal with his emotional problems. They both acknowledge that his problems stem from a bereavement which he has not dealt with, and there are other family linked problems such as an absent father.

He has a supportive Mother who has tried her best to be an advocate for him including writing to their local MP to try to gather support for supportive Mental Health services that can meet his needs. They feel he is a case of 'revolving door' where he is displaying chaotic behaviour which is also a cry for help that results in him being imprisoned frequently as a way of managing his distress. They are despairing of ever finding the type of support that they feel he needs and welcomed the opportunity to share their experiences in the hope that their needs can be better understood and served by the NHS and other services.

NB Since this interview CS10 has been given a 'mental health treatment order' and is reporting benefit from this.

Mental health: Findings from Probation Officers

A number of Probation Officers were of the view that Community Offenders with mental health problems received a patchy health service with examples including:

- A sense that Community Offenders are being given medication by GPs rather than referrals for a specialist assessment
- Those that have been referred and seen by the Mental Health Service appear to be 'seen every now and then by a Psychiatrist'
- There appears to be a lack of continuity in mental health service staff allocated to individuals. This means they *"have to keep re-telling their story which is very traumatic for them"*
- *"A reluctance from mental health teams to work with people with Personality Disorder, …. people who mis-use substances or who have a mental health problem"*
- Some thought ADHD was a 'label' that Community Offenders adopted as a distraction from addressing concerns
- Some expressed concern at a lack of a consistent service to support those with a genuine ADHD diagnosis, and that the effects of the condition were mis-understood. Concerns about young people diagnosed with ADHD *"falling out of the school system and then being able to continue with their therapy"*
- *"Being offered six Counselling sessions is not enough to help deal with the level of mental health distress many Community Offenders experience".*

A number of Probation Officers thought that individual 'narrative therapy' – a chance to tell their stories - could be a helpful intervention for Offenders if they know that is the process as many of them have had traumatic experiences in the past. Occasionally Offenders were offered group therapies however this offer was often declined. Reasons given for this included:

- *"they are so isolated within themselves that they find the group dynamics too difficult"*
- *"they don't feel listened too, they feel labelled and normally have lost all hope"*
- *"they find it difficult to trust and it takes them time to build relationships as they have normally been hurt/abused by others in the past".*

Mental health: Findings from GPs
One of the GPs interviewed expressed that *'Where Mental Health is concerned it's a potentially complex and difficult area.'* On transfer from prison to the community some of the conditions can be treated and managed relatively well in a Primary Care setting such as Depression, Anxiety and moderate Personality Disorders.

However, the above GP noted that a small number of individuals have more serious conditions such as bi-polar depression, schizophrenia or multiple diagnoses. These are more complex and require specialist treatment from the Mental Health sector, and an individual may have to see two different specialists. This can be compared to people who have more than one physical health diagnosis having to see different specialists. However, for people with serious and enduring mental health conditions seeing a range of specialist can be challenging due to the limitations their condition can put on their motivation and capacity to organise themselves. The GP reported that *"in some cases of multiple diagnoses it can be very difficult to treat effectively at all."*

Summary: The main challenge Community Offenders and Probation Officers expressed is in trying to get consistent and specialist support for those with moderate through to serious mental health conditions. These problems include:
- A lack of access to sustainable Counselling Services and Talking Therapies
- The length of time between referral, diagnosis and treatment
- Trying to access a consistent mental health support worker for their condition which is made more challenging by the re-organisation of health services as people move onto new positions
- A perception that there is a lack of understanding, willingness and capacity amongst the Mental Health services to work with Community Offenders who experience mental health distress.

One of the GPs was able to highlight the complexity of treating a person with complex mental health needs (the numbers are relatively small but the conditions are serious and contribute to their re-offending) and the need for different specialities within the medical profession to treat those people. This would suggest that there is a good case for identifying specific trained workers who can support those people to manage their condition and treatment, and to act as an advocate for them with services.

Drug misuse and alcohol

Drug mis-use and alcohol: Findings from Community Offenders
Four out of the 10 had histories of extensive drug use – many starting as teenagers on 'softer drugs' leading to Heroin and Crack. All those stated they were now 'clean' and spoke very highly of the team supporting them from KCA. Those who were on drug replacement therapy appeared, and were keen to report, that they were determined to stay 'clean' as they knew the havoc their drug use has caused to them and their families. Some were motivated as they had several children or a young baby, and one who had an alcohol misuse history had a girlfriend and was moving in with her.
Most claimed low alcohol use although there were two people who stated their offences were alcohol related – often as a consequence of binge drinking in response to a crisis. (See case studies in Mental Health section for details.)

Case study CS6 is a 37 year old male who has been a Heroin user for 15 years and has been in and out of Prison throughout this period. He has been out of Prison for 9 months and states he intends to stay out as he doesn't want to go back – he feels disinterested in drugs since he has been clean and being in prison showed him he didn't want to have anything to do with drugs and prison.

CS6 has had experiences of 'Anxiety' in the past which he linked to his drug use. Recently he had a return episode of Anxiety for which he sought medical help from his GP. He was seen by Locum GPs whom he felt did not listen to him and judged him to be a 'junkie' and prescribed medication that made him feel 'weird'. Once he was seen by his named GP he felt he was taken seriously and the GP has since changed his medication to an anxiety specific one. He is now feeling better although he still has problems with sleeping.

CS6 feels that he is now well supported by services such as KCA, IOM, his GP and his family and that he stands a chance of recovery and making a life for himself.

Drugs and alcohol: Findings from Probation Officers

One Probation Officer reported that in their experience *"accessing the Mental Health services is very hit and miss and many are refused support if they have substance misuse issues".*

One felt that *"GP's often take a dim view of substance misuse issues and don't come across as supportive. Individuals with Mental Health and/or substance misuse issues are often chaotic, or don't have the ability to follow up on services and I feel there should be more responsibility on the services to pursue these individuals and maintain regular contact with them, rather than waiting for the individuals to contact them, which often doesn't happen."*

Summary: The one striking feature was how much Community Offenders valued the support that they felt was available to them – they knew where to go for drug and alcohol services and valued the support they were given. They all had a degree of insight into their own responsibility in being successfully re-habilitated and what they had done to cause their situations.

However, it appeared that this determination will be challenged – they are clearly vulnerable and need a strong multi-agency team supporting them. This is in addition to how important family support was to them where it is given.

Services

Communication between Prison and Community Health Services

Findings from Community Offenders

There were two people who have either a specialist medical condition or range of complex health needs one of which was presented as an earlier case study. The following case study reflects concerns about the care they had received whilst in prison and how well he felt he had been treated once discharged back into the community.

Case study CS3 is in his late 20s and is moving in to live with his girlfriend and has a new job. He has had drink related offences which have resulted in custodial sentences. CS3 has a rare blood disorder that requires specialist treatment, regular blood tests and medication according to blood levels.
CS3 feels that he was not satisfied with the treatment that he received whilst in prison. He felt the 'Doctors were very slow in responding to my particular condition. They didn't come across very often and I had to wait to be seen and my condition gets worse as it needs regular blood tests and prescribing according to the list.' 'If it had been a request for Methadone the system would have given me this more quickly.'

However, he feels that although he has to see one of a number of GPs when he goes to his registered GP practice they treat him well as does his Consultant. This includes following him up when he 'goes off the rails and it means I get back in control of my condition.'

It is re-assuring that in some cases Community Offenders health needs are met once discharged, however the interviewee in the above case study is highly motivated.

However, there were it would appear, from other Community Offenders' perspective, that when they are released from Prison having health needs that there is a problem in communication between the Prison Health Service and community based NHS services including mental health. A number reported that they felt 'alone' in finding their way back into the community NHS services without a clear referral mechanism and support to access the particular specialist services.

These problems are exacerbated when the Offender has no fixed address and is unable to receive letters with appointments.

Findings from GPs
The GPs recognised *"Healthcare, whether taking pace in the community or a prison setting should be compatible and information should flow between the two"…. "there is a need to ensure continuity for patients with chronic conditions on release".*

However, it was reported that GP medical records are held using three different computer systems with only one (Systm1) being compatible with the prison health record system; and this system is used the least by GPs. Therefore it is much harder for information to flow between the services, and there is a reliance on the 'patient' taking a paper record of their health needs from the Prison health system back to the GP's. These often are mislaid by the Offender, not given priority whilst they are trying to find their feet in the community or not given to a GP as not in the same area as their GP.

There is also a confidentiality concern if the Offender does not wish their GP to know they have been in Prison.

If people move into a new area or back into the community a GP or the prison health service should try to help link them into local services. GPs thought this seems to work with HIV/Sexual Health and Drug and Alcohol services quite well, however, felt this works less well with Mental Health.

Summary Supporting Community Offenders who have moderate to serious health conditions on their discharge from Prison is important in helping them readjust and manage their condition as well as reintegration into the community. It would appear that there are concerns that this transition is not being well managed. From the Community Offenders perspective they feel they are left to find their own way around the health system if they don't work closely with their GP. From the GPs perspective there is a frustration about the

problems with sharing information between the Prison Health Service and themselves. This is an area that could benefit from a review as to how to improve communication.

GPs and Locums

GPs and Locums: Findings from Community Offenders

Nine out of the ten Community Offenders interviewed were registered with a GP and had not had a problem with registering. On the whole they spoke highly of the support they had from their GP.

However, there was a theme of when seen by a Locum GP they felt *'not listened to, not taken seriously'*, judged to be a junkie and given a prescription to get them out of the door.'

GPs and Locums: Findings from Probation Officers

The IOMS service reported that they perceive an on-going problem with GP's appearing to be providing medical certificates/notes to individuals quite readily. They report that Community Offenders can then use these to cover absences they have from their Probation Orders. They report the "difficulty is, the medical certificates state 'not fit for work'. This is fine in cases of Un-Paid Work, but if they are being asked to attend supervision, Alcohol Treatment Requirement etc. these appointments are not requiring them to work and they may therefore be well enough to attend such appointments. It is not then supporting the individuals in addressing their issues with probation and facing the responsibilities of their order."

There was a perception that there were not regular 'script' or prescription reviews for people on complex prescriptions or drug replacement therapies from some Probation Officers.

GPs and Locums: Findings from GPs

Some of the findings from GPs have been included in other sections where they are concerned with the topic being discussed. However, there were other issues they raised.

Locations and GP registrations People are sent to Kent prisons from all over, and are released back into other areas than they may have come from, often into temporary addresses, away from the areas they may be registered with a GP. They are entitled to register with a new GP but need to provide proof of residence – again difficult if in temporary accommodation or 'sofa-surfing.'
They could also be removed by the Kent Primary Care Agency (NHS administration for GPs) from the GP registration list if they don't access the service for long periods, for example if in prison for a long period.

Medication compliance Where an offender/patient has a condition that requires anti-viral therapy such as Hepatitis C or HIV it is important that they take their medication regularly and without a break. Hence, for some cases those are diagnosed relatively close to discharge from prison that treatment will be delayed until they are back in the community and can see a local specialist service. This reduces the chances of a break in compliance (which can have serious implications for the efficacy of the drugs) which could occur due to being unsettled in the transfer. This transfer and linking in with local community based services has to be supported by a responsible officer in the cases where there is a pattern of chaotic lifestyle.

'Sick notes' A GP has a professional responsibility to have a Therapeutic relationship with their patient. Hence, *"if the patient is saying they have a bad back the GP has to make a judgement about whether to refuse a sickness certificate, and this is not easy to do".*

This also goes for Prescription requests especially if the patient has a history of medication. No doubt, however, that there will be GPs who will issue a prescription 'a bit too readily'.

Summary: A repeated theme being reported by GPs and mirrored from a different perspective by Community Offenders in other sections is the concern that relates to Housing and fixed address. GPs are the gatekeepers to the Health Service and exist to support and assist people into and around the services to help manage and promote their health and well-being. However, their ability to fulfil this role can be hampered by a lack of fixed address for some of the higher end need Community Offenders.

GPs also articulate a different relationship they have to fulfil with their patients – a therapeutic one.

Dental services

Four out of the ten were registered with a Dentist. Reasons given for not registering were mainly that they did not see it as a priority, some would have to travel some distance and some said it was easier to have dental work whilst in Prison as it was free. When asked why not registered reasons given included *'not a priority…. would have to travel to access an NHS registered Dentist, there is a cost associated with dentistry and ….could get it done for free when in prison'*. None reported any problems with registering if they wanted to.

Case study CS2 is in his late 20s and has a young child under one year old. He is due to start Voluntary work soon and is looking forward to this. He has a history of drug taking since he was 9/10 years old which progressed to Crack and Heroin addiction and resulted in him being in and out of prison. He has now been treated for his addiction and is trying to make a new start motivated by having a young child.

CS2 is keen to stress that access to Dental services are very important for drug users both in and out of prison. Although he was referred to a dentist whilst in prison he did not a chance to take advantage of this as he was not in for long enough. In addition, since his recent discharge he has not registered with a dentist as he has to travel to the next town for a NHS registered one and that costs travel money.

CS2 feels that since his recent discharge he has been well served by services such as Probation and the Drug Treatment clinic.

Summary: Patients with a substance misuse problem have special dental needs. There are specific conditions associated with particular types of drug use. In addition, substance misusers are more likely to experience dental anxiety. This may be because many patients with substance misuse problems have not previously sought regular dental care, tending to attend only when in pain. Chaotic lifestyles associated with substance misuse do not favour regular dental or medical care. Lifestyle habits contribute to poor dental health as well as substance misuse.[iii] There is also evidence that substance misusers report difficulty accessing dentistry.[iv]

Housing

A common theme was the importance of Housing and a permanent address. Most were having support from Housing and spoke highly of the support they had from their Probation Officers in engaging with Housing services and applying for benefits.

Case study CS5 is a 21year old male who was brought up by Foster parents as his parents were heroin addicts. He says he does not take drugs as has seen the damage they can do. He has been in and out of Prison and finds the biggest challenge for him is his lack of permanent housing. He has been homeless on a number of occasions and feels this has a direct impact on his mental health.

During one Prison detention CS5 was diagnosed with Depression and prescribed medication. He was discharged with one week's worth of medication but didn't register with a GP. 'Couldn't be bothered – was homeless so registering with a GP was the last thing on my mind. When you don't have somewhere to live it's a problem'.

Within two and a half months CS5 was back in prison but only started seeing the 'Medical people' after one and a half years. He was referred by a Prison Officer as showing 'strange behaviour'. Saw a Dr who wanted to restart the medication but as he had only one week to go he couldn't and was discharged with a follow up letter which he subsequently lost.

CS5 hasn't looked for help as he 'feels ok as now living in a hostel …*living place so important – I know what I'm doing and just make choices. It makes all the difference having somewhere to live.'*

Case study CS8 is a 58 year old male who has had two spells in Prison. He has recently re-located to the area which is some distance from where he used to live as a fresh start. This was helped by the offer of a 'decent place to live' which he feels is making a difference to his motivation and health.

He has early heart disease which is managed by medication. He has had no problem with registering with a new GP. However, he has found it harder to find an NHS Dentist in the locality.

CS8 feels that he has had good support from the Probation and Housing service. This is helping to motivate him to find an opportunity to do some voluntary work to improve his chances of getting back into work.

Housing: Findings from GPs

The GPs emphasised how important Housing was as a gateway into health services and improving health.

'Until someone has a home it is difficult to be plugged into the health service' therefore housing is a key issue. This has can have a knock-on effect on risky lifestyle behaviour such as drug and alcohol use, food and smoking.'

'The main concern is Housing and in particular where they are discharged and are homeless and/or move between temporary accommodation or 'sofa surf'.

This makes it hard for services to keep track of people and offer consistent care or follow up care, and to follow up as main GP if they are moving around.'

'*Substance misusers tend to go in and out of temporary accommodation but they seem get picked up by KCA. There are generally more concerns linked to Mental Health services with consistency of service.'*

'Those who have a Learning Difficulty and / or Mental Health problems need more support to take up independent living when discharged from prison.'

Summary: One of the GPs summed up the link between housing and health *'Discharging people with an address to go to is so important for helping give people more security and act as a base for managing their health, plus easier for services to link with them.'*

The links between housing and homelessness, health and mental health have long been established. There is much evidence of the link between poor housing and health inequalities. It is therefore reasonable to suggest that ensuring Community Offenders are linked into routes to being Housed before they are discharged from Prison will potentially have a positive impact on their health and well-being.

Health Trainers

There are a growing number of Health Trainers working in parts of Kent where there are also high numbers of Community Offenders.

The manager of the Thanet based Health Trainer submitted the following information.

Most clients on probation come to us for a whole host of emotional wellbeing issues such as Housing, Employment, Benefits, Mental Health, Education, or for the less literate form filling, debt management, etc. The Health Trainer will offer up to 6 sessions of support to help them access the services they need and even go with them if it is necessary. We aim to help them to help themselves and once signed off have the skills to carry on alone. Primarily we deal with issues around health such as diet, exercise, alcohol, smoking and drugs but the secondary emotional wellbeing issues need to be dealt with first so they are in the right place mentally to be able to tackle the health issue. The Health Trainer can signpost clients out to other services when needed but still continue to support the client.

Often the Health Trainer is the first person who they feel listens to their real needs and what they want so often many issues come out that need to be addressed around wellbeing and health. We try to concentrate on the issues that are most important and work through the rest over time. The client will be contacted for a maintenance check 3 months after signoff and if they are not managing their goal or wish to come back to the service for a different issue they can. The gap is to stop over dependence on the Health Trainer.

There are Health Trainers working in Margate Probation (for over a year now), Sittingbourne Probation (since December), Shepway Probation (for over 6 months) and Maidstone Probation (for about 3 months). They work very well as they can really address the emotional wellbeing issues such as to go with them to appointments where they are uneasy or help them to fill in forms and explain anything they do not understand in a less rigid way than they may have been used to, with someone recruited from the area they live in and who understands the day to day problems or anomalies of that area. Help from next door rather than advice from above. Plus they know everything that is happening in that area such as local support groups or exercise classes, etc. that may not be known about by others.

Discussion arising from the qualitative research

The Bradley Report[v] recognised that the needs of released prisoners are complex, and many of these elements are interlinked. For example, if mental health problems are not resolved, an individual may have difficulty gaining and keeping employment, or problems in maintaining accommodation which in turn may impact on their chances of employment. There is a need to ensure that people coming out of prison have access to a range of services to tackle these issues. Liaison and diversion services will play an important role in facilitating access to these services.

The findings from the qualitative research for this HNA have sought to identify the experiences and views of a range of people providing services for Community Offenders, as

well as from the offenders themselves. It is by no means comprehensive and there are areas that warrant further investigation. However, there are issues that have been identified that complement the findings from other research for this HNA and help to build the evidence base for the findings and recommendations.

Each section above has a short summary conclusion which will not be repeated in full here. However, the following points seek to summarise key themes:

- It was clear that Community Offenders were aware of healthy lifestyle messages and knew where to go for support. However, following up on this was not a priority for many as they felt they had more pressing concerns such as housing and staying 'out of trouble'.
- Supporting Community Offenders who have moderate to serious health conditions on their discharge from Prison is important in helping them readjust and manage their condition as well as reintegration into the community. It would appear that there are concerns that this transition is not being well managed, and the transfer of health information and communication between services does not work as well as it could with too much emphasis left to the Community Offender who is often in a vulnerable state with other priorities. This is an area that could benefit from a review as to how to improve communication, information systems and joint working.
- The potential benefits of increasing access to longer term Counselling and Talking Therapies, and Health Trainers for Community Offenders.
- The complexity of treating a person with complex mental health needs (the numbers are relatively small but the conditions are serious and contribute to their re-offending) and the need for different specialities within the medical profession to treat those people. This would suggest that there is a good case for identifying specific trained workers who can support those people to manage their condition and treatment, and to act as an advocate for them with services.
- The links between housing and homelessness, health and mental health have long been established. There is much evidence of the link between poor housing and health inequalities. It is therefore reasonable to suggest that ensuring Community Offenders are linked into routes to being housed before they are discharged from Prison will potentially have a positive impact on their health and well-being.

Recommendations

- All services including primary care, community services, public health commissioned services and mental health services need to be proactive in engaging with this group of offenders through integrated commissioning and meeting NICE standards.
- Access to mental health services should be made simple so that community offenders easily know (a) who is their primary care MH worker and (b) how to access services
- Mental health services have to be responsive commissioning by monitoring and evaluating services to ensure that this happens.
- Offender management staff need to continue to ensure that the health needs of community offenders leaving prison are assessed, ensure that their client needs are recorded and referred onto appropriate services and that this activity is appropriately monitored by the relevant oversight organisation.
- The current good practice between Kent Probation and the commissioned Personality Disorder service should be audited and shared with commissioners and partners.
- There is currently a commissioned resource for mental health counselling which currently meets a level of demand. Consideration should be given to working with community commissioned MH counselling services e.g. MHCO to provide extra capacity and possible streamlining.
- Commission training for all front line staff in IBA for alcohol misuse.
- Current commissioned services for community offenders who are not managed on license and perceived to be at greater risk of hazardous and harmful behaviour due to not having had a prison regime, need to be proactive in providing services for this group and this should be a KPI.
- Due to a high smoking prevalence rate in this group public health commissioned services need to prioritise and target this group for smoking cessation services and harm minimisation services.
- Given the many changes to structures and personnel in the health and offender management organisations that there is a published list of organisational leads for health for everyone to access on relevant websites.
- Improve health literacy of offender management staff e.g. use of NHS Choices, Live It Well, and how to access relevant and reputable health improvement websites.
- Develop the use of the Healthy Living Pharmacy for smoking cessation for community offenders.
- PH Kent KCC and the emerging offender management organisations develop a “Healthy Probation” health improvement/promotion model utilising relevant stakeholders to drive forward community offender health improvement linked to clear outcomes with locality targets set. (Also see UK Health Promoting Prison and Healthy Returns Initiative in USA (California).
- That PH Kent KCC and the emerging offender management organisations agree a common data set relating to the physical and mental health needs of community offenders and ensure that there is regular update for relevant lead individuals and Partnerships through a Health & Wellbeing Group.
- Develop clear contact arrangements with Kent & Medway CCGs regarding offender health to enable better and more robust engagement between primary care clinicians and community offenders.

- Current data integration and data quality across partner organisations is poor and needs to be better integrated between Kent County Council, the NHS and Offender management organisations as part of Better Care/Integrated Health & Social care.

APPENDIX 1 Kent and Medway Community Offenders Health Needs Assessment

Interview framework

Date of completion: _____ Interview number/first part of postcode: _____

Please explain the confidential nature of this interview: *used for research purposes to improve access to health and well-being advice and support and healthcare services. No names will be used.*

What is your age? ☐☐ Male ☐ Female ☐ Are you registered disabled? Yes ☐ No ☐

How would you describe your ethnicity? _____

1. In general, would you say your health is:
   Please read out and tick one box only.

   Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐

2. Do you have any of the following health problems?
   Please read out and tick all that apply.

   Asthma ☐ Diabetes ☐ Mobility problems ☐

   Heart or circulation problems Inc. high blood pressure ☐ Mental health or learning difficulty ☐ Any other health problems ☐

If heart and circulation problems ticked, please ask which heart or circulation problems:

_____

_____

If Mental health or learning difficulty ticked, please ask responder to say more if they wish:

_____

_____

If any other health problems ticked, please ask which other health problems do they have:

_____

_____

If yes answered to any of the health problems, please ask: are you currently seeing any health service for treatment? Yes ☐ No ☐

Please say more if you wish:

_____

_____

3. During the past 4 weeks, have you had any of the following problems with your regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
Cut down the amount of time you spent on work or other activities?		
Accomplished less than you would like?		
Had any problems with sleeping?		

4. Have you heard of 'five a day'?

Yes	No

How many portions of fruit and vegetables do you think you eat per day?
Please tick one box only.

None ☐ 1 – 2 portions ☐ 3 – 4 portions ☐ 5 portions ☐ 5+ portions ☐

5. Do you do any moderate exercise such as walking, gardening, shopping, cleaning for 30 minutes each day?

Yes	No

Do you do any more strenuous exercise such as running, cycling, swimming or other for 30 minutes more than once a week?

Yes	No

6. Do you smoke cigarettes?

Yes	No

If yes, ask: how many do you smoke per day?

_____

Have you ever looked for help or thought about quitting?

Yes	No

Would you like some information on help available with quitting?
If yes, please give leaflet about local Smoking Cessation services.

Yes	No

7. Do you drink alcohol?

Yes	No

If yes ask: how many units per week do you drink?
Explain what constitutes a unit.

_____

If you think you may be drinking more than is good for your health, would you like some information about local alcohol support services?
If yes, please give leaflet about local Alcohol service.

Yes	No

8. Do you use any illegal substances such as cannabis?

Yes	No

If yes ask: have you ever looked for help or thought about seeking help with this?
Please give leaflet about local Substance Misuse services.

Yes	No

9. Do you know where to go for information and support on sexual health services? *If no, please give leaflet about local sexual health services.*

Yes	No

10. Have you had any of the following vaccinations? *Please tick all that apply.*

MMR (Measles, Mumps and Rubella) ☐ Hepatitis B ☐ Hepatitis C ☐

Others, please state:

11. Are you registered with a local Doctor?

Yes	No

If yes, please ask: Which practice are you registered with?

If no, please ask: have you tried and had difficulty registering?

Yes	No

If yes, please ask: what was the problem?

If not registered with a GP, please give them a leaflet about how to register with a GP.

12. Are you registered with a Dentist?

Yes	No

If no, please ask: have you tried and had difficulty registering?

If yes, please ask: what was the problem?

If not registered with a dentist, please give them a leaflet about how to register with a Dentist.

13. Are you currently seeking any support from other services such as:
Please read out and tick all that apply.

Housing		Training		Employment		Managing your finances	

Others, please state:

_____

_____

_____

	Yes	No
14. Is there anything you would like us to know about how we can support your health and well-being?		

If yes, please ask: how can we support your health and well-being?

_____

_____

_____

_____

_____

Many thanks for your help with this research which will improve how we offer local NHS and other services.

ADDITIONAL SPACE FOR COMMENTS (PLEASE NOTE QUESTION NUMBER COMMENT RELATES TO)

_____

_____

_____

_____

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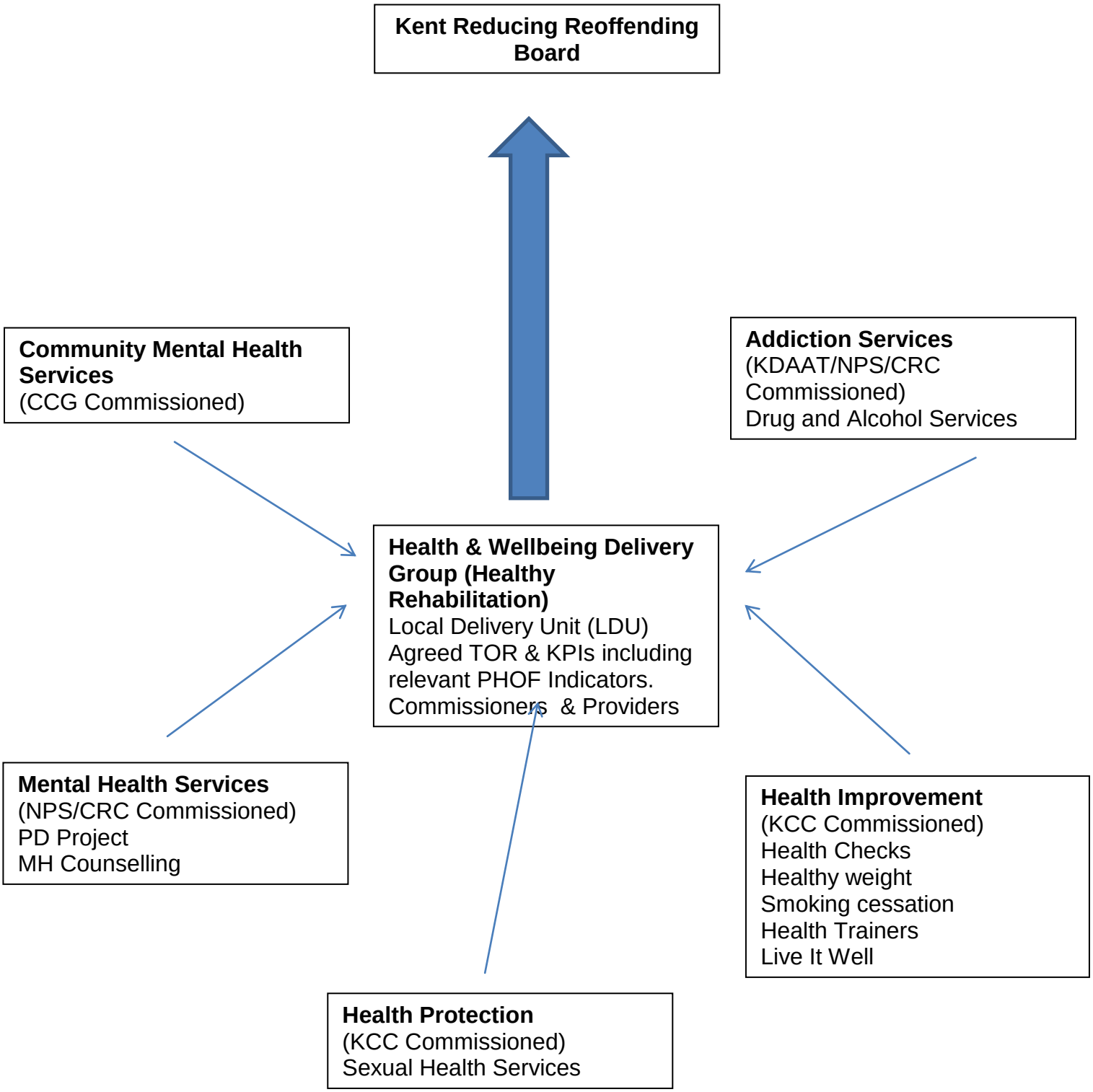
Appendix 2 Suggested Governance Model for Community Offenders Health and Well-being Overview & Scrutiny



APPENDIX 3 List of Abbreviations

ADHD	Attention deficit hyperactivity disorder
ASPD	Antisocial personality disorder
ATR	Alcohol Treatment requirement
CCGs	Clinical Commissioning Groups
CMO	Chief Medical Officer
COCOA	Care for Offenders: Continuity of Access
COPD	Chronic obstructive pulmonary disease
COSMIC	Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study
CP	Community Payback
CRC	Community Rehabilitation Company
CRI	Crime Reduction Initiatives
CS	Case Study
CVD	Cardio Vascular Disease
DH	Department of Health
DLO	Drug Liaison Officer
DNA	Did not attend
DRR	Drug Rehabilitation Requirement
GP	General Practitioner
HALT	Health and Lifestyle team (Medway)
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HNA	Health Needs Assessment
IAPT	Improving Access to Psychological Therapies
IBA	Identification and Brief Advice
IOM	Integrated Offender Management
IRCs	Immigration Removal Centres
JSNA	Joint Strategic Needs Assessment
KCA	Kent Council for addiction
KCC	Kent County Council
KDAAT	Kent Drug and Alcohol Action Team
KPI	Key Performance Indicators
LDUs	local delivery units
MAPPA	Multi-Agency Public Protection Arrangements
MDAAT	Medway Drug and Alcohol Action Team
MH	Mental Health
MMR	Measles, Mumps & Rubella
NFA	No fixed abode
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NPS	National Probation Service
OASys	Offender Assessment System
OGRS	Offender Group Reconviction Scale
OM	Offender Manager
OMU	Offender Management Unit
PD	Personality Disorder
PH	Public Health

PHP	Personal Health Plan
PSO	Prison Service Order
SAR	Specified Activity Requirement
SIP	Kent and Medway Serious Incident Panel
STD	Sexually Transmitted Disease
WHO	World Health Organisation

APPENDIX 4 REFERENCES

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