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Health needs assessment of adult offenders across the criminal justice system on Merseyside

Cath Lewis and Alex Scott-Samuel

Liverpool Public Health Observatory

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PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Authors:
Cath Lewis and Alex Scott-Samuel, Liverpool Public Health Observatory

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Liverpool Public Health Observatory was founded in the autumn of 1990 as a research centre providing intelligence for public health for the five primary care trusts (PCTs) on Merseyside: Liverpool, St.Helens and Halton, Knowsley, Sefton and Wirral. It receives its core funding from these PCTs.

The Observatory is situated within the University of Liverpool's Division of Public Health. It is an independent unit. It is not part of the network of regional public health observatories that were established ten years later, in 2000.

Contact e-mail obs@liv.ac.uk.

With input from the project Working Group:
Stephanie Gallard
Richard Holford
Richie Humphreys
Nick Kayani
Tom Knight
Tony Mercer
Anjila Shah
Ian Shaw

The working group would like to thank all the organisations and individuals who have helped us with this health needs assessment.

Contents

List of tables

1. Executive Summary

1.1 Introduction

Liverpool Public Health Observatory was commissioned by Merseyside Directors of Public Health to carry out a health needs assessment (HNA) of adult offender health across the criminal justice system on Merseyside. HNA is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

The HNA covers the 3 prisons on Merseyside: HMP Liverpool, Altcourse and Kennet, as well as offenders on probation and in police custody across Merseyside. Because the majority of female offenders from the Merseyside area who are sent to prison are sent to HMP Styal, Styal was also included. This HNA covers offenders aged 18 and upwards. A health and wellbeing needs assessment of young offenders aged 10-18 is due for completion in December 2012.

As part of the health needs assessment, quantitative data on prevalence of mental and physical health problems, as well as a wide range of other measures, were collected from the 4 prisons, as well as from Merseyside Probation Service. In addition, fifty eight interviews were carried out with key stakeholders, including offenders and key health care staff.

1.2 Background information

Research has demonstrated that the health of offenders is in general significantly worse than that of the population as a whole, particularly in terms of mental health problems, addictions and blood borne virus. Health of female offenders is particular poor, as highlighted in the Bradley Report, and when women are sent to prison families are far more likely to break down. Other ways in which imprisonment exacerbates health problems include many offenders losing their accommodation and/or employment whilst in prison. Prisoners are more likely to be from minority ethnic groups than the general population, and the proportion of foreign national prisoners has also increased steadily over the past decade. Although less research has been done with offenders who are on probation, research shows that health needs of those on probation are similar to those of the prison population.

1.3 The criminal justice system on Merseyside

1.3.1 Prison population

There are three prisons within the Merseyside area: HMP Liverpool, Altcourse, and Kennet. HMP Liverpool and Altcourse are Category B prisons, while HMP Kennet is a Category C prison. As the majority of female offenders from the Merseyside area are sent to HMP Styal, this prison was also included. Quantitative data was collected from HMP Styal where available, and interviews were conducted with women at the prison who were from the Merseyside area. The majority of interviews conducted in the male prisons were also with prisoners from the Merseyside area. Table 1 below gives an overview of prisons included in the HNA.

Table 1: Overview of prisons included in the HNA

	Liverpool	Altcourse	Kennet	Styal
Category of prison	B	B	C	Female and young offenders
Status	Public funded	Private	Public funded	Public funded
Sex of prisoners	Male	Male	Male	Female
Operational capacity	1423	1324	342	460
Type of health care services	On-site health care unit	On-site health care unit	On-site health care unit	On-site health care unit

Operational capacity taken from 'Inside Time' (http://www.insidetime.org/index.asp: last accessed April 2012)

1.3.2 Probation population and offenders with court orders

The area covered by Merseyside Probation Trust is split into 6 areas: North Liverpool, South Liverpool, Wirral, Sefton, Knowsley and St Helens. Merseyside Probation Trust had a caseload of 7,942 offenders on 29th February 2012, 813 of whom were female, and 7129 were male. On 19th March 2012, the Trust employed a total of 190.45 FTE Probation Officers, and 101.99 FTE Probation Service Officers. The latter work with offenders who present a low to medium risk of harm to others and have a lower risk of re-offending. Health care is also delivered in a number of probation offices: nurses provide services including vaccination for Hepatitis A and B, wound management and mini

mental health assessments, as well as signposting to other agencies, at Old Swan and Kirkdale Probation Centres. The Options service at South Knowsley Probation Centre is the only full GP practice that operates in a probation office. A team including GPs, nurses, a dedicated social worker, as well as health and social care navigators, skilled in dealing with housing and employment issues and providing signposting for offenders to other agencies, deliver the service.

1.3.3 Police custody

There are 8 Custody Suites across the Merseyside area. 6 of these Suites are operational 24 hours per day, 365 days per year: They are Birkenhead (Wirral), Copy Lane (Sefton), Southport (Sefton), St. Helens, St. Anne Street (Liverpool City Centre), and Belle Vale (South Liverpool). The other 2 Suites, at Wavertree (Liverpool City Centre) and Kirkby (Knowsley), are opened when required.

1.4 Interviews and focus groups with offenders and health care staff in prisons and in the community

Between August 2011 and February 2012, interviews, and a small number of focus groups, were carried out with a total of 58 people. 38 of these were offenders, and 20 were members of staff. 13 of the offenders were women, and 25 were men. 22 interviews with prisoners were carried out, and 4 of these were young offenders aged 18-21. 3 interviews were carried out at HMP Liverpool, 6 at Altcourse, 8 at Kennet and 5 at Styal. Interviews at HMP Styal were carried out with prisoners who were from the Merseyside area, and where possible interviewees from the male prisons were from the Merseyside area. Interviews were also conducted with 10 members of health care staff in prisons.

Interviews were conducted with 16 offenders in the community. The majority were on probation, although some had been referred directly from the courts. As there are many professionals working with offenders in the community, it was agreed focus would be on treatment agencies, including Addaction, Mersey Care and CRI Integrated Recovery Treatment Service. Staff at two projects targeted specifically at female offenders, Liverpool's Turnaround Project and Tomorrow's Women Wirral, were also interviewed, together with clients who attended these projects, as well as staff working with people who are in police custody. Interviews lasted between 20 and 50 minutes. Interview schedules are provided in appendices 1-4.

1.4.1 Interviews –summary of findings

Prisons

- Offenders and staff were generally satisfied with prison health care. Health was generally easy to access, and prisoners were able to focus on themselves and their health needs.
- Areas for improvement included the need to submit 'applications' for health care at most prisons, which could deter prisoners with low literacy levels from seeking help.
- Offering the option of health care on prison wings would increase uptake.
- Prisoners reported that questions about accommodation, employment, benefits etc, were sometimes only raised shortly before discharge, which did not give sufficient time to plan.
- Prisoners and health care staff also mentioned that it was easy to access drugs in prison. However, being sent to prison provided an opportunity for offenders who were determined to withdraw from drugs to do so, with the help of excellent, easily accessible services.
- Other areas of concern for prisoners and prison health care staff included transfer to hospital: the need to be handcuffed to 2 prison officers was embarrassing for offenders, and waiting for 2 officers to be free could result in a delay in prisoners receiving hospital treatment.
- Although females tended to have shorter prison sentences, being sent to prison often had a greater negative impact on their health. They reported losing residency of their children whilst in prison. Women lost accommodation whilst in prison, and because they served relatively short sentences, it was difficult to get appropriate accommodation in place prior to discharge: the same was true of issues such as employment, benefits etc. Health care staff reported that there was a perception among sentencers that sending women to prison would help them deal with their problems (e.g. drug/alcohol problems), although the reality was very different.

Probation/other

- Wider health needs such as accommodation, employment and benefits advice were key concerns. Accommodation immediately following discharge was not always conducive to preventing re-offending, e.g. offenders with drug problems were sometimes sent to hostels

where there was easy access to drugs. Vulnerable offenders including female offenders did not always feel safe using accommodation/services that were used by male offenders.

- Employment and training needs were of priority health concern. Although provision for some groups of offenders was excellent, and agencies such as ACHIEVE NW support offenders across Merseyside, more comprehensive 'signposting' for offenders was necessary.
- Services that were specifically targeted at female offenders, including the Turnaround Project and Tomorrow's Women Wirral, were highly valued by both offenders, and staff, in terms of meeting health care needs. Women were supported to keep families together in a way that they would not have been had they been sent to prison. They were able to access services under one roof, including access to benefits and legal advice, confidence building/assertiveness and job skills, that would help prevent re-offending. Women were also able to get basic needs met, e.g. they were able to get food, and had access to a washing machine.
- Offenders and health care staff expressed the view that services were in place, should offenders be willing/able to use them. Offenders were more likely to use services where they could access several services under 'one roof', or drop-in services that they were able to access immediately. As many offenders had chaotic lifestyles, and also generally had a high number of appointments to attend, it was advantageous wherever these could be minimised.

1.5 Recommendations

The following recommendations have been produced based upon the national and local evidence, as well as best practice of what is effective in improving the health and wellbeing of offenders.

1.5.1 Core recommendations

- All core recommendations should be implemented by Merseyside Offender Health and Social Care Board.
- Link up computer systems detailing health needs. The EMIS system should be accessible to all prisons. When responsibility for providing health care in custody suites transfers to Merseyside Health Services in 2013, SystmOne should be available to custody health staff.
- In relation to IT systems, coding needs to be done in a systematic way across prisons, in order to allow comparisons between prisons, and make transfers between prisons smoother.
- Maintain and strengthen links between, as well as within, different agencies working with offenders. When sufficient data on outcomes is available, later in 2012, commissioners should consider the cost-effectiveness of rolling out the Community Prison Offender Passport[1] to identify health needs and ensure continuity of care, to all offenders on Merseyside, particularly those who are serving sentences of less than twelve months.
- Conduct interviews with staff including CARATS[2] team, accommodation teams etc, to get a better local understanding of wider health issues.
- Ensure health care is easily accessible. Provide drop-in clinics, and provide services 'under one roof' where possible: an example of this is the 'Options' service, at South Knowsley Probation Centre, which should be rolled out across the whole of Merseyside where cost-effective. Offer the option of health care on prison wings.
- Provide services that offenders feel safe using, e.g. Turnaround Project, Tomorrow's Women Wirral etc, were highly rated by female offenders.
- Monitor trends that show that the offender population is ageing, and respond with health care that is appropriate to the age profile of the population.
- Due to the ageing population described above, commissioners should consider end of life care when planning prison health care.
- A standardised register of offenders with disabilities should be kept in prisons and by Merseyside Probation Trust.
- If more detailed recommendations are required for each institution, carry out a greater number of interviews for each institution.
- Ensure needs of health care staff working with offenders are addressed, including staff development and debriefing/ongoing support.

[1] See Appendix 4
[2] CARATS stands for Counselling, Assessment, Referral, Advice and Throughcare services

- When Offender Health functions transfer to the National Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs) become responsible for offenders who are in contact with the criminal justice system, strong links will need to be developed between the NCB and CCGs.
- Review this HNA once all new structures described above are in place.
- Review this HNA following publication of NICE guidelines on the effectiveness and cost-effectiveness of care for health problems among prisoners, and of public health guidance for addressing mental health problems for those in the criminal justice system.
- Consider if we need a North West offender approach to addressing health needs of offenders. At the very least, offender health care needs to be delivered on a Merseyside footprint.

1.5.2 Recommendations for prisons

- Ensure that health care is easily accessible. Review the need for completing 'applications' to access health care. Offer the option of health care on prison wings.
- Ensure that dental problems are treated prior to discharge from prison. Ensure that waiting lists for dental care are kept to a minimum.
- Address issues around drug use among prisoners.
- Ensure the needs of health care staff are met, e.g. the need to debrief following incidents, and staff development, in order to reduce sickness absence rates and staff turnover. Look at the impact of prison regimes on health care staff, and any ways to minimise this.
- Maintain a register of prisoners who have disabilities.

1.5.3 Recommendations for HMP Liverpool

- Look at adapting cells in the future to accommodate wheelchairs. Provide an in-house pharmacy to alleviate issues around timely dispensation of medication.
- At the end of 2012, assess the impact of HMP Liverpool receiving prisoners from courts outside Liverpool. Merseyside Offender Health and Social Care Board to assess to ensure adequate health care staff are in place. Prison health care staff to look at any additional capacity and security issues.

1.5.4 Recommendations for HMP Altcourse

- Maintain a register of prisoners with chronic disease, in line with other Merseyside prisons.

10.5 Recommendations for HMP Styal

- Assess physical resources available for health care. Many of the facilities were built some years ago, making delivery of effective health care more challenging.
- Ensure liaison with appropriate professionals in advance of women being discharged back to the Merseyside area.

1.5.6 Recommendations for Merseyside Probation Trust

- Focus on wider health needs, with adequate 'signposting' to agencies who can support offenders into employment/training, including ACHIEVE NW, and agencies who can provide support with housing, including the specialist accommodation unit provided by Merseyside Probation Trust. Consider use of the Community Prison Offender Passport.
- Review data on outcomes from relatively new women's projects, such as Tomorrow's Women Wirral and the Turnaround Project, when at least a year's worth of data is available.
- Roll out the above projects systematically across Merseyside.

1.5.6 Recommendations for sentencers

- Look at alternatives to prison for wherever appropriate. Roll out Conditional Cautions, currently used for female offenders in Liverpool and Birkenhead, throughout Merseyside.

1.5.7 Wider health needs – recommendations

- For those leaving prison, ensure that discharge planning starts as someone is sent to prison/release dates are known. Focus on wider health needs including accommodation, employment/training and benefits advice, with adequate 'signposting' to agencies who can support offenders, including ACHIEVE NW for training/employment support, and Merseyside

Probation Trust's specialist accommodation unit for support with housing. Consider the use of the Community Prison Offender Passport (see appendix 5).

- Ensure that support with the above issues is consistent across the whole of Merseyside.
- Monitor the impact of the changing landscape with regards to employment support, such as changes to The Work Programme.

1.6 Conclusion

In conclusion, strengthening liaison between different agencies working with offenders is the most important recommendation, alongside ensuring adequate 'signposting' for offenders to appropriate services, and ensuring computer systems are linked wherever possible, to allow health care staff to access the fullest possible medical history. An integrated health pathway for offenders would also help to achieve this. In the main, services are available, but services need to be as easy to access as possible. Services should be targeted towards specific offender groups.

The landscape in which offender health is delivered is in a state of change. From April 2013, offender health care will be delivered by Health Partnership Boards. There is a need for links to be developed between this board and health and wellbeing boards, and also with Clinical Commissioning Groups.

Health needs assessment of adult offenders across the criminal justice system on Merseyside

Full report

2. Health needs assessment overview.

2.1 Aims

- To determine the healthcare needs of the Merseyside offender population.
- To investigate the extent to which current service provision is addressing the healthcare needs of the Merseyside offender population.

2.2 Objectives

- Assess existing evidence on offender health needs.
- Analyse available quantitative data relevant to offender health needs in Merseyside.
- Describe key characteristics of the offender population in Merseyside relevant to commissioning health services.
- Detail current health service provision across the offender pathway in Merseyside.

2.3 Scope

- Adult offenders in prison custody (on remand and serving sentences) in Merseyside and at HMP Styal (interviews at HMP Styal were conducted with women who were from the Merseyside area only). Young offenders aged 18-21.
- Male and female adult offenders attending Merseyside Probation Trust, including those serving community orders and those attending probation under licence having previously served a prison sentence, as well as offenders who are in police custody.

2.4 Key steps

- Obtaining necessary ethics/research committee approvals.
- Conducting a literature review looking at relevant studies.
- Assessment of available relevant data sources.
- Collation and analysis of available quantitative data.
- Compiling a detailed description) of the offender population on Merseyside.
- Mapping of offender population flows around the criminal justice system in Merseyside.
- Mapping of current service provision across the offender pathway.
- Acquiring data from key stakeholders (including offenders) to identify priority health issues, barriers to accessing services and barriers to delivering services.
- Analysis of data obtained from stakeholders.
- Drawing conclusions from data and making recommendations

2.5 What is health needs assessment?

Health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities (NICE, 2005)[3].

[3] (http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf)

3. National context

3.1 The prison population

There were 88,179 people in prison on 2nd December 2011, according to the Ministry of Justice (Berman, 2012). The prison population grew rapidly between 1993 and 2008. Reasons for this include increases in the average custodial sentence length, increased use of indeterminate sentences and increased numbers recalled to prison following breaches of their licence. However, the rise in the prison population has slowed considerably since the summer of 2008 with an average annual increase of 1 per cent, until the public disorder seen in UK cities from 6 to 9 August 2011. The public disorder had an immediate impact on the prison population, with an increase of 2% of the prison population in September 2011. The flatter trend prior to the disorder partly reflected the introduction of the Criminal Justice and Immigration Act (CJIA) 2008[4].

An increasing proportion of sentenced prisoners are serving sentences for the most serious offences. As at 30 September 2011, 28% of the sentenced population had committed violence against the person offences, an increase from 21% in 2000. Similarly, the proportion serving sentences for sexual offences increased from 10% in 2000 to 14% in September 2011. Whereas, over the same period, there were falls in the proportions serving sentences for burglary, theft and handling and motoring offences[5].

The number of non-criminals in prison rose by 20% to 1,174 in September 2011. Non-criminal prisoners are largely immigration detainees, and the increase partly reflects the opening of Morton Hall as a new Immigration Removal Centre in May 2011. Imprisonment rates in the UK are high in comparison to other European countries. The UK had 151 prisoners per 100,000 population in 2009, according to the Ministry of Justice (2009a), the second highest rate in Western Europe.

3.2 Ethnicity and nationality

At 30 June 2010, over one-quarter of the prison population whose ethnicity was recorded were from a minority ethnic group, according to the Ministry of Justice. Table 2 below shows that there are almost twice as many Asian or Asian British people in the prison population than in the population as a whole, and seven times as many Black or Black British people, with Chinese people also over-represented in the prison population. The proportion of foreign national prisoners in the prison population has also increased steadily over the past decade: on 31st December 2011, there were 11,077 foreign national prisoners in England and Wales, around 13% of the total prison population.

Table 2 : Prison population by ethnic group

	General population (%)	Prison population (%)
White	92.3	73.7
Mixed	0.8	3.6
Asian or Asian British	3.9	7.3
Black or Black British	2.0	14
Chinese	0.9	1.4

Source: Table A1.18 Offender Management Caseload Statistics 2010, Ministry of Justice

3.3 Female prisoners

There were approximately 4,100 females in prison at the end of December 2011 (Berman, 2012), accounting for 4.7% of the prison population, an increase of 1.5% from a year earlier. The majority of female prisoners are held in female only prisons, of which there are 14 in England. The spread of women's prisons means that many women are held at a great distance from their homes, resulting in additional health issues such as separation from children. In 2007, the average distance adult women in prison were held from their home or committal court address was 57 miles, compared to an average of 49 miles for men (Prison Reform Trust, 2009).

[4] (http://webarchive.nationalarchives.gov.uk/+/http://www.justice.gov.uk/publications/criminal-justice-bill.htm).
[5] (http://www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/oms-quarterly.htm

4. Literature review: health status of prisoners and offenders

4.1 Health status of prisoners

4.1.1 Mental health

Brooker et al (2007) conducted a literature review on the mental health of prisoners. All the studies included in the review confirmed that the incidence of mental disorder is grossly over-represented in prisoners compared to the population as a whole. This confirmed an earlier seminal report by Singleton et al (1998), which found that around 90% of prisoners had at least one mental disorder, including alcohol abuse and drug dependency. 78% of male remand prisoners had a personality disorder, which the authors defined as 'patterns of behaviour or experience resulting from a person's particular personality characteristics which differ from those expected by society and lead to distress or suffering to that person or to others'. Singleton and colleagues also found that intellectual functioning measured using the Quick Test (Ammons and Ammons, 1962), showed that the median Quick Test scores obtained for prisoners were lower than would be expected in the general population. Male prisoners are also six times more likely to have been a young father than men in the general population (Department of Health, 2005). Table 3 below compares some key characteristics of the health of prisoners with those of the population as a whole. It shows that those in the prison population were more than thirteen times more likely to have been taken into care as a child and ten times more likely to have been excluded from school than the population as a whole. They were thirty times more likely to have been homeless than the population as a whole, almost twice as likely to be hazardous drinkers and more than four times more likely to have used drugs in the year prior to going to prison.

Table 3 : Key characteristics of the health of prisoners compared to the general population

Characteristic	General population (%)	Prison population (%)
Run away from home as a child	11	47% of male sentenced prisoners 50% of female sentenced prisoners
Taken into care as a child	2	27
Regularly truanted from school	3	30
Excluded from school	2	49% of men and 33% of women
No qualifications	15	52% of men and 71% of women
Numeracy at or below Level 1 (the level expected of an 11 year old)	23	65
Reading ability at or below Level 1	21-23	48
Unemployed before imprisonment	5	67
Homeless	0.9	32
Suffer from two or more mental disorders	5	72% of male and 70% of female sentenced prisoners
Psychotic disorder	0.5	7% of male and 14% of female sentenced prisoners
Drug use in previous year	13	65% of male and 55% of female sentenced prisoners
Hazardous drinking	38	63% of male and 39% of female sentenced prisoners

Source: Social Exclusion Unit [6]

4.1.2 Drug misuse

In 2010, 15% of men and 24% of women in prison were serving sentences for drug offences (Ministry of Justice, 2011). However, there is a much wider group of prisoners whose offence is in some way drug related. Shoplifting, burglary, vehicle crime and theft can be linked to drug misuse. Over half of prisoners (55%) report committing offences connected to their drug taking, with the need for money to buy drugs the most commonly cited factor (Ramsay, 2003). Singleton et al (1998) also found that one in four adult prisoners had engaged in activities likely to put them at risk of infection with HIV, and Hepatitis B and C, with 24% of males and 29% of females having injected drugs. Risky sexual behaviours were also common: half of all male prisoners reported having two or more sexual partners

[6] (http://www.socialexclusionunit.gov.uk/downloaddoc.asp?id=64: cited Berman 2012).

in the last year, but not consistently using condoms. Drug use within prisons is also a significant issue.

4.1.3 Learning disabilities

The Bradley Report (Department of Health, 2009) highlighted the disproportionately high number of people with learning disabilities and mental health problems in the criminal justice system (CJS). Research shows high numbers of offenders with unidentified learning difficulties or learning disabilities: the Prison Reform Trust (2007) estimated level of unmet need to be 32% within the CJS. Lord Bradley was asked to look at diverting people with mental health problems and learning disabilities away from the CJS. The main findings of the report (Department of Health, 2009), included interventions to help vulnerable people as soon as possible in the criminal justice system. It also called for a separate review, looking at prevention and intervention for options for children and young people who are at risk of offending. In terms of prison health care, the report calls for appropriate community alternatives for vulnerable offenders, saving up to 2,000 prison places per year. The report called for better screening for learning disabilities and mental health problems when people arrive at prison. It also calls for greater continuity of care when people enter and leave prison.

4.1.4 Dental health

A study comparing dental health of prisoners in the North West of England with the 1998 UK Adult Dental Health Survey (Jones, 2005), showed that prisoners enter prison with twice as many decayed teeth (mean 4.2) as the general population of the North West of England (mean 1.9). Reasons why dental health is worse in the prisoner population include oral neglect, often due to drug/alcohol problems or chaotic lifestyles of some offenders, combined with the effects on oral health of drug/alcohol use, smoking, and poor nutrition (Harvey et al, 2005). Recommended targets in the Department of Health's Strategy for Modernising Dental Services for Prisoners in England states that appointments for routine care should not exceed six weeks from the time of asking, although these targets are often exceeded (Department of Health, 2003). On a national level, delivery of dental health care in prison is complicated by turnover of prison population, meaning it is sometimes impossible to complete courses of treatments, as well as recruitment and retention of dental staff, leading to an increase in waiting times to see a dentist – and outdated facilities and equipment (Harvey et al, 2005).

4.1.5 Women's health

In March 2007, the Corston review of vulnerable women in the CJS was commissioned by the Home Office following the deaths of six women at HMP Styal. The Corston report (Home Office, 2007) highlighted the poor health status of women in prisons. Although women make up less than 5% of the prison population, they account for around half of self-harm incidents.[7] A large scale UK study of female prisoners (Plugge et al, 2006), found that 27% of female prisoners had been paid for sex prior to coming into prison. 85% smoked and 75% had used illegal drugs in the six months prior to imprisonment. A history of childhood neglect and abuse was far more common in female prisoners than in women as a whole. Primary care consultation rates and admission rates to prison healthcare centres are high in women's prisons compared with other prison types, and far higher when compared with women in the community (Joint Prison Service et al, 1999). Corston recommended that 'Community solutions for non-violent women offenders should be the norm'. Despite this, the female prison population is still increasing. Corston states that women should be offered community penalties such as unpaid work schemes, praising schemes which operate during hours which take account of childcare responsibilities. The report also highlighted the pioneering Liverpool Community Justice Centre, which aims to reduce crime and antisocial behaviour with the help of local people and by tackling the underlying causes of offending[8].

According to the Corston Report (Home Office, 2007), sentencers were concerned that the Criminal Justice Act 2003 required them to treat breaches of community orders more harshly than they felt was appropriate. Corston believes that orders for women must take into account domestic responsibilities as well as other issues influencing compliance, such as lack of confidence and distrust of conventional service providers. When women are arrested, diversion at the point of arrest and from police stations needs to be firmly embedded within the criminal justice structures.

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[7] http://www.justice.gov.uk/search?collection=moj-matrix-dev-web&form=simple&profile=_default&query=self-harm

6. (http://www.bbc.co.uk/news/uk-england-merseyside-12544138: last accessed May 2012)

Female offenders are also less likely to be given bail than male offenders. The Corston Report states that two-thirds of the women who go to prison do so on remand, and more than half of them do not go on to receive a custodial sentence. Social care charity PSS found that 66% of women sent to prison have children, and 95% of those children do not stay in the family home once their mother is sent to prison. The new economics foundation has found that for every pound invested in support-focused alternatives to prison, £14 worth of social value is generated to women and their children, victims and society generally over 10 years (New Economics Foundation, 2008). Following the publication of the Corston Report, followed by the Bradley Report (Department of Health, 2009), a number of women's projects were set up around the country, as an alternative to sending women to prison. The main aim is to prevent the breakdown of families after a woman is sent to jail, as well as reducing re-offending[9] .

Health needs that are specific to women include maternity care, gynaecology and care of babies in prison. According to the Prison Reform Trust (2009), there are 8 mother and baby units in prisons and secure training centres, providing accommodation for up to 75 mothers and babies at any one time. There were two births a week to female prisoners between April 2005 and July 2008.

4.1.6 Overcrowding

A prison is overcrowded when the number of prisoners held exceeds the establishment's Certified Normal Accommodation. At the end of January 2012, 62% of prison establishments in England and Wales were overcrowded, according to the Ministry of Justice (2011), and anecdotal evidence suggests that, as overcrowding disrupts work to prevent re-offending, it can lead to an increase in re-offending.

4.1.7 Specific challenges of delivering health care in prisons

It has been acknowledged for many years that prisoners are entitled to receive the same range and level of health care service as are available in the community (HM Prison Service, 1994). The government's National Delivery Plan (Department of Health, 2009b), published in response to the Bradley Report (Department of Health, 2009), also states the importance of equity of access: offenders should receive health and social care services appropriate to their needs regardless of race, gender, disability, age, sexual orientation, religion or belief. In addition to the fact that offender health tends to be poorer than that of the population as a whole, particularly in certain areas including mental health and addictions, challenges include delivering health care within the prison regime. This includes conflict between the security role and the caring role faced by health care staff in prisons, as well as constraints provided by the prison environment. Prisoners are 'locked down' at certain times, so health care is scheduled around this, but emergencies may mean that prisoners are 'locked down' for additional periods of time, which has a knock on effect on health care, e.g. nurses may be available to deliver health care, but prisoners are not able to receive it. When offenders are transferred to hospital, two prison officers are needed to accompany them, but delays in two officers being available also has an impact upon health care staff – in an emergency situation, one member of health care staff will have to stay with the prisoner, which impacts on other duties that they need to carry out. There are many other ways in which the prison regime impacts upon health care, for example prisoners who are moving wings might miss health care appointments because of this.

4.2 Health status of offenders outside prisons

Although, at the end of September 2007 there were 80,855 people in custody in England and Wales (Ministry of Justice 2007a) compared to 175,416 offenders being managed by the National Probation Service (Ministry of Justice 2007b), less is known about offenders' health needs in community settings. If offender health is to be effectively addressed this needs to be addressed (CSIP 2006). The poor health of prisoners does not suddenly remit on release and might even get worse, as the disciplining of life and reduced access to alcohol and drugs in prison might afford a protective factor for many offenders. Many offenders in the community also seem to have difficulty accessing mainstream health services, and to over-use crisis services such as Accident and Emergency Centres but enjoy little in the way of preventative healthcare or health promotion (Department of Health 2007).

Solomons and Rutherford (2007) report a lack of research on the mental health needs of people serving community sentences. The data that they found included Mair and May's (1997) comprehensive interviewing of a sample of 1213 people on probation caseloads. 46% of male

[9] (http://www.jmu-journalism.org.uk/#/news-386/4545645385: last accessed July 2011).

probationers between 16-44 years of age reported long term illness or a disability compared to 26% in a matched age group within the general population. The authors conclude that there is clear evidence of a higher incidence of self-reported health problems in probationers that are similar to rates amongst prisoners. Freeman's (2003) study used Short Form 36 Health Survey (SF-36) alongside other measures to evaluate outcomes for drug dependent offenders in Australia, and found that offenders' health was worse than that of the general Australian population. Hagedorn and Willenbring (2003) carried out a similar study of 60 American offenders in a drug court probation programme. They found lower SF36 physical component summary and mental component summary scores that showed worse subjective health for offenders who were being managed in the community than the general population. The sample group of offenders also reported higher levels of anxiety and depression.

Hatfield et al (2004) undertook a 12 month cohort study of 467 individuals in probation approved premises. Staff members reported that 25.1% of the offenders had a known psychiatric diagnosis, 34.3% had drug misuse and 30.6% had alcohol abuse problems. A study using tracking methods relied upon objective data such as contact with local mental health services, forms of treatment and staff coding the complexity of need (Keene et al 2003). The researchers identified that 13.6 % of the total probation population were in contact with the local mental health trust, with the proportion higher amongst female offenders (19.6%). Only 53% of offenders who probation officers had assessed as having poor mental health were in contact with mental health services, but 445 clients who had not been assessed by probation as having mental health problems had used mental health services.

The variance in these figures on prevalence of health problems amongst community managed offenders might largely be because different measures of health were used (Brooker et al 2007). However, all the studies showed that mental and physical health problems in these offenders were worse than in the population as a whole. Mortality rates are also very high among offenders living in the community. Sattar (2001) found that community offenders are four times more likely to die than the general male population, and twice as likely to die as prisoners. Half of offender deaths occurred within 12 weeks of release from prison, and almost half of them were related to drugs or alcohol.

Many studies also show that offenders within the community are socially excluded, and experience difficulty in accessing services to meet their needs (Social Exclusion Unit 2002, Department of Health 2007). Skeem and Louden's (2006) review of research on offenders who were being managed in the community showed that services for mentally disordered offenders receiving community supervision are not geared towards the needs of this population. Vaughan & Stevenson (2002) conducted a survey which found that mentally disordered offenders were disenchanted with mental health services and were unlikely to seek help themselves.

5. The prison population – HMP Liverpool, Altcourse, Kennet and Styal.

5.1 Overview

There are three male prisons in the Merseyside area – HMP Liverpool, Kennet and Altcourse. Because the majority of female prisoners who are from the Merseyside area are sent to HMP Styal, this was also included in the health needs assessment. Table 4 below gives an overview of prisons included in the HNA. The same quantitative data was collected from all the prisons, recognising that it might not be possible to replicate every measure across all prisons, or obtain national comparative data. At HMP Styal, interviews were only conducted with women who were from the Merseyside area. Disease prevalence data was taken in November 2011.

The following data collection periods were agreed with each prison:

- HMP Liverpool and Kennet from1st Nov 2010 to 31st October 2011.
- HMP Styal 1st April 2011 to 31st October 2011.
- HMP Altcourse 1st January 2011 to 31st November 2011.

Clinical information on the management of prisoners' health needs is recorded on a database called SystmOne. Whilst SystmOne is used to good effect to monitor and performance manage the day to day operation of the Healthcare Centre at the prison, analyses of SystmOne data have shown that a reliance on data from this system is likely to lead to significant underestimates of health need of the prison population (Doyle, 2008). For this reason national prevalence data has also been included where possible. Unless otherwise stated, national prevalence data is taken from 'Psychiatric morbidity among prisoners in England and Wales' (ONS, 1998). The implementation of SystmOne into all prisons in the North West should mean that comparisons will be easier in the future, leading to improvements in health care planning.

Table 4: Overview of prisons included in the HNA

	Liverpool	Altcourse	Kennet	Styal
Category of prison	B	B	C	Female and young offenders
Status	Public funded	Private	Public funded	Public funded
Sex of prisoners	Male	Male	Male	Female
Operational capacity	1423	1324	342	460
Type of health care services	On-site health care unit	On-site health care unit	On-site health care unit	On-site health care unit

Source: 'Inside Time' (http://www.insidetime.org/index.asp: last accessed April 2012)

5.2 Prison population on Merseyside by age.

Table 5 shows the prison population on Merseyside by age. Data collected by age varied by prison. Over 90% of the prison population at Merseyside prisons are aged under 50. Men in their 20s are the largest group. Although numbers of prisoners aged over 70 remain relatively small, this group is growing as the population ages. This trend will need to be monitored, in order to ensure the health needs of this group can be met effectively. This will include end of life care[10].

[10] MacMillan Cancer Support has developed prison standards for end of life care, in collaboration with HMP Durham (http://www.endoflifecareforadults.nhs.uk/case-studies/a-new-set-of-standards-for-end-of-life-care-in-prisons).

Table 5*: Prison population by age*

	Liverpool		Altcourse		Kennet		Styal	
Age	№	%	№	%	№	%	№	%
18-19	N/A	N/A	99	7.4	N/A	N/A	56[11]	13.0
21-29	513	40.4	575[12]	43.1	140	39.7	98[13]	22.7
30-39	386	30.4	380	28.5	119	33.7	132	30.6
40-49	273	21.5	203	15.2	64	18.1	97	22.5
50-59	69	5.4	48	3.6	25	7.1	39	9.0
60-69	25	2.0	20	1.5	<5	N/A	9	2.1
70-79	5	0.4	7	0.5	<5	N/A	N/A	N/A
80 plus	0	0	<5	N/A	N/A	N/A	N/A	N/A

Source: Information supplied by prisons, Nov 2011 for HMP Liverpool and Kennet, May 2012 for HMP Altcourse, March 2012 for HMP Styal.

5.3 Ethnicity

Table 6 below shows the population of Merseyside prisons by ethnic group. This data was not available for HMP Styal. The majority of the prison population on Merseyside is British. In both the prison population and in the general population[14] on Merseyside there are less people from minority ethnic groups than there are in England as a whole, and numbers were generally too small to make comparisons between the general and prison populations. Nationally, however, 73.7% of the prison population is white, compared to 92.3% of the prison population, meaning that minority ethnic groups are over-represented in the prison population nationally (Berman, 2012).

Table 6: Prison population by ethnic group

	Liverpool		Altcourse		Kennet	
Ethnicity	**№**	**%**	**№**	**%**	**№**	**%**
British/mixed British	1054	83.6	1055	79.0	279	79.0
Asian	9	0.7	8	0.6	<5	N/A
Black	18	1.8	8	0.6	<5	N/A
Chinese/Other	11	0.9	19	1.4	<5	N/A
Mixed	12	1	17	1.3	<5	N/A
White	27	2.1	21	1.6	20	5.7
Irish	9	0.7	9	0.7	<5	N/A
Not known	125	9.8	198	14.8	44	12.5

Source: Information supplied by HMP Liverpool Altcourse and Kennet, November 2011.

5.4 The prevalence of physical health problems and lifestyle issues

Table 6 below shows the prevalence of physical health problems, and lifestyle issues, for the 3 prisons on Merseyside. This data was not available for HMP Styal. The table shows that smoking rates at the 3 prisons are lower than national prevalence rates in prisoners, which are estimated to be around 80% (ONS, 1998). Rates of smokers wishing to quit are lower for the prisons on Merseyside than national rates, which are estimated to be around 43%: 21% of prisoners wanted to quit at HMP Liverpool, 12.2 at Altcourse and 17% at Kennet. As only motivated smokers who wish to quit are likely to engage with stop smoking services, there is a huge challenge in supporting this population to stop smoking, when most are not motivated to do so yet.

[11] Number aged 18-21
[12] Number aged 20-29
[13] Number aged 22-29
[14] Data source: neighbourhood.statistics.gov.uk: last accessed Nov 2011

Table 6: Prevalence of physical health problems and lifestyle issues.

	Liverpool		Altcourse		Kennet		% national prison pop.
Health problem	№	% prison pop.	№	% prison pop.	№	% prison pop.	
Asthma	219	17.2	200	16.8	61	17.3	N/A
Hypertension	40	3.1	N/A	N/A	16	4.5	N/A
Epilepsy	78	6.1	52	4.4	29	8.2	N/A
Diabetes	46	3.6	34	2.8	9	2.5	N/A
Speech and language problems	13	1.0	8	0.7	<5	N/A	11
Smoking rates	824	64.8	931	78.3	257	72.8	80
Smoker wishing to quit	267	21.0	145	12.2	60	17.0	43

Source: HMP Liverpool, Altcourse and Kennet, November 2011.

5.4 Prevalence of mental health problems

Table 7 below shows the prevalence of mental health problems recorded on SystmOne at the 3 Merseyside prisons, where available. This data was not available for HMP Styal. National prevalence data has been added where available. On the whole, numbers recorded on SystmOne were lower than would be expected based on national prevalence data. National research including research carried out by the Sainsbury Centre for Mental Health (2008) also shows rates for prisoners to be far higher for prisoners than the population as a whole, and highlights the need for mental health to remain a top priority in Merseyside prisons.

Table 7: Prevalence of mental health problems

	Liverpool		**Altcourse**		**Kennet**		**National prevalence (%)**	
Health problem	**№**	**%**	**№**	**%**	**№**	**%**	Remand	Sentenced
Depressive disorder	199	15.7	160	13.5	41	11.6	N/A	N/A
Anxiety disorder	129	10.2	270	22.7	27	7.6	N/A	N/A
Self-harm	124	0.8	164[15]	13.8	14	4.0	N/A	N/A
Personality disorder	29	2.3	12	1.0	3	0.8	78	64
Post-traumatic stress disorder	14	1.1	7	0.6	11	3.1	5	3
Phobias	7	0.5	<5	N/A	<5	N/A	10	6
Panic disorder	6	0.5	13	1.1	N/A	N/A	6	3
Obsessive-compulsive disorder	<5	N/A	<5	N/A	<5	N/A	10	7
Functional psychoses	N/A	N/A	22	1.9	N/A	N/A	10	7
Neurotic disorder (in past week)	N/A	N/A	120	10.1	N/A	N/A	N/A	N/A

Source: HMP Liverpool, Altcourse and Kennet, November 2011.

5.6 Prevalence of Blood Borne Virus

In common with other health issues, figures of offenders with blood borne virus recorded on SystmOne are lower than would be expected. This is due in part to initial difficulties in recording health issues on SystmOne, following its implementation. We collected figures of offenders with blood borne virus from SystmOne in November 2011 for all 3 Merseyside prisons. Numbers for Hep B and C were too low to be reported at HMP Liverpool, whilst 11 prisoners were reported to have HIV, around 0.87% of the population. Numbers of prisoners with blood borne virus were too low to report at HMP Altcourse. Numbers were too low to be reported for hepatitis B and HIV at HMP Kennet.

National prevalence data shows that rates of blood borne virus are far higher in the prison population than in the population as a whole, meaning that the prison is an ideal environment to undertake screening and vaccination. However, this may be more problematic where prisoners are serving shorter sentences and there is less time for vaccination programmes to be completed.

HMP Altcourse now receives funding from the Health Protection Agency to raise awareness about Hepatitis B, and vaccinate more offenders against it. In addition, a new Hepatitis C service that was

[15] Self-harm and suicide

introduced at HMP Liverpool, Altcourse and Kennet in 2011 ensures active engagement of staff with promoting Hep C awareness. It is a Specialised Secondary Service, which is normally delivered in a hospital, but is now delivered by the same secondary care staff in a prison setting. From October 2011, a programme of identification and treatment for blood borne virus began at HMP Kennet, with 8 prisoners undergoing active Hepatitis C treatment between October 2011 and April 2012. The issues of recording health problems should also be alleviated in part due to appointment of a member of staff who will be responsible for ensuring that coding is standardised across the Merseyside prisons.

5.7 Prevalence of substance misuse

Table 8 below shows the presence of substance misuse at the 3 Merseyside prisons. Misuse varies significantly by prison: for example, 10.7% of the population of HMP Liverpool were recorded on SystmOne as having misused heroin. At HMP Altcourse, the proportion who had misused heroin was only 5.5, around half the proportion at HMP Liverpool. The figure was 7.4% for HMP Kennet. Drug use among prisoners is also a significant problem, and was mentioned in the interviews that we conducted at all 4 prisons. The use of drugs at HMP Liverpool is an issue that has been highlighted in previous Board reports (Ministry of Justice, 2010) for HMP Liverpool. The report acknowledged that work had been done by management and staff to address this issue, but recommended that greater resources should be directed to assist in stopping the supply of drugs and tackling the addiction of many prisoners.

Table 8: Prevalence of substance misuse

	Liverpool		Altcourse		Kennet	
Health problem	**№**	**%**	**№**	**%**	**№**	**%**
Alcohol Misuse	N/A	N/A	N/A	N/A	14	4.0
Cannabis Misuse	19	1.5	64	5.4	10	2.8
Heroin Misuse	136	10.7	65	5.5	26	7.4
Crack Cocaine Misuse	19	1.5	19	1.6	<5	N/A

Source: HMP Liverpool, Altcourse and Kennet, November 2011.

5.8 Dental health

Collecting prevalence rates of tooth decay in Merseyside prisons was problematic, but a study comparing dental health of prisoners in the North West of England with the 1998 UK Adult Dental Health Survey (Jones, 2005), showed that prisoners enter prison with twice as many decayed teeth (mean 4.2) as the general population of the North West of England (mean 1.9). Reasons for this include oral neglect, often due to drug/alcohol problems or chaotic lifestyles of some offenders, combined with the effects on oral health of drug/alcohol use, smoking and poor nutrition (Harvey et al, 2005). On a national level, delivery of dental health care in prison is complicated by turnover of prison population, meaning it is sometimes impossible to complete courses of treatments, recruitment and retention of dental staff – issues around recruitment were mentioned in interviews with staff at HMP Kennet, leading to an increase in waiting times to see a dentist – and outdated facilities and equipment (Harvey et al, 2005). The interviews showed that oral health is an area that offenders are willing to address once in prison, although some concerns were raised in interviews about waiting times for non-emergency dental work. Prisoners were also concerned that scale and polish was not available, meaning prisoners were concerned about neglecting preventive oral health, although there is little evidence for the effectiveness of this procedure in terms of maintaining oral health.

5.9 Physical and human resources : all prisons

Table 9 below shows the facilities available to each of the 4 prisons. One of the main findings was that while HMP Altcourse, Kennet and Styal provide in-house pharmacy, HMP Liverpool does not have an in-house pharmacy, despite it being a large prison. Providing an in-house pharmacy at HMP Liverpool this would alleviate the issues around timely dispensation of medication that were mentioned in the interviews (NPC, 2012). Additionally, HMP Liverpool, standard sized cells are not large enough to accommodate wheelchairs, meaning that any prisoners using wheelchairs have to use inpatient cells, reducing capacity. The poor quality of cell accommodation at HMP Liverpool, is an issue that has been previously raised in Independent Monitoring Board Reports (Ministry of Justice, 2010) as an issue that needs to be addressed. At HMP Styal, many of the facilities were built some

years ago, making delivery of effective health care, as well as compliance with all safety standards, more challenging.

Table 9: Physical and human resources

Facilities	Liverpool	Altcourse	Kennet	Styal
Reception screening rooms	2	2	1	2
Consulting rooms	14	13	4	14
Inpatient beds	26	12	None	None
Pharmacy	None in-house	In-house	In-house	In-house.
Other facilities: (including dental surgery, records store room, sluice, bathroom, storerooms)	Yes to all	1 dental surgery, 1 records store room, 1 sluice,1 bathroom, 1 storeroom	1 dental suite	1 dental surgery.1 digital dental x-ray. 1 dental equipment decontamination room. 2 sluices. 1 bathroom with bath in mental health resource centre.

Source: HMP Liverpool, Altcourse and Kennet as of November 2011 unless otherwise stated. Information from HMP Styal taken February 2012 unless otherwise stated.

Table 10 below shows the staffing profile at HMP Liverpool, Altcourse, Kennet and Styal. The poor health status of female prisoners, particularly in terms of mental health, is well documented (e.g. Department of Health, 2009), and this is reflected in increased provision to meet mental health need at HMP Styal, e.g. numbers of mental health staff are proportionately higher at HMP Styal than at the male prisons. National statistics (ONS, 1998) show that mental health problems are generally higher in female prisoners than in male prisoners. For example, rates of anxiety and depression were 36% for female remand prisoners, and 31% for sentenced, compared to 26% and 19% for their male counterparts (ONS, 1998). Rates of suicidal thoughts in the last week were 23% for female remand prisoners and 8% for sentenced, compared to 12% and 4% for male prisoners. HMP Liverpool provides a dedicated health care reception team Monday to Friday, 1pm until 9pm, and on Saturday afternoons. They are one of the few prisons to offer this six days a week. However, HMP Liverpool now receives from courts outside Liverpool, increasing prisoner turnover and workload on health care staff. The impact of this will need to be assessed at the end of 2012, both by prison staff, to look at capacity and security issues, and by Merseyside Offender Health and Social Care Board, to ensure appropriate health care staff are in place.

Table 10: Staffing profiles

Nature of human resources	**Liverpool** Staff employed by LCHT unless otherwise stated	**Altcourse** Staff employed by G4S unless otherwise stated	**Kennet** Staff employed by LCHT unless otherwise stated.	**Styal** Employed by East Cheshire NHS Trust unless otherwise stated. All services not listed as employed by East Cheshire NHS Trust are delivered under sub-contract to East Cheshire NHS Trust as the lead provider
Manager	DDU: 2 plus Deputy Manager Primary Care Psychology: 1 CMHT: 2 All the above are employed by Mersey Care	1	1	2 WTE
Prison Custody Officers (PCO) funded by substance misuse		PCO: 6 PCOs funded by substance misuse:3	None specifically allocated to health care	None specifically allocated to health care
Professionals allied to medicine				
Clinical psychologists	Primary Care Psychologists: 1.6 Mersey Care CMHT: 0.35 Mersey Care 6 employed by LCHT	Nil	Nil	Engaged on a case by case basis Employed by Greater Manchester West Foundation Trust
Occupational therapists	N/A	Nil	Nil	1 X WTE. Employed by Greater Manchester West Foundation Trust
Speech and language therapists	N/A	Nil	Nil	N/A
Physiotherapists	1	1 Sub-contracted	1 LCH	External clinics utilised: service to commence April 2012, 1 session per week.
Pharmacists	Pharmacy provider is Lloyds	1	Pharmacy provider is Triangle	1 WTE Primecare Ltd
Pharmacy technician	DDU: 1 employed by Mersey Care	1.63	0	1.6 WTE. Primecare Ltd/ East Cheshire Trust
Nurses				
Clinical Lead		1	Manager as above	2
Senior Nurse		4		3 WTE primary care 1.3 WTE women's health 1 WTE learning

				disabilities/ mental health 1 WTE substance misuse 1 mental health in-reach employed by Greater Manchester West Foundation Trust
RN	N/A	16 RN substance misuse	5	19 WTE
RMN	DDU:8 (Mersey Care) CMHT: 4 (Mersey Care)	8	1	12 employed by East Cheshire NHS trust and Greater Manchester West Foundation Trust
HCA	CMHT: 0.60 (Mersey Care) DDU:8 (Mersey Care) 11 LCHT	6 4 substance misuse		18 WTE
Doctors and dentists				
Trained GPs	3	4 sub-contracted	1	1.7 WTE 1 X session with female GP per week. Children in the mother and baby unit are registered with a local GP surgery
General dental practitioners	N/A	1 sub-contracted	1	0.6 WTE. Also 1x session with dental surgeon per month
Psychiatrists	DDU:4 sessions per week plus 4 staff grade sessions CMHT: 2 sessions per week	1 sub-contracted	1	3 sessions per week (employed by Greater Manchester West Foundation Trust)
Other medical specialists	Primary Care Psychologist: 3	1 optician 1 chiropodist	1 optician 1 chiropodist	Optician – 26 clinics a year/ 13 in 6 months (subcontracting practitioner) 1 podiatry session per fortnight to commence. 1 WTE family substance worker, substance misuse. 0.1 WTE Specialist Respiratory Nurse
Admin staff	DDU:2 Primary Care Psychology: 1 CMHT: 0.86	3	3 part-time	6.5 WTE
Voluntary sector	Nil	Nil	Nil	Nil
Other	Primary Care Psychology: 1 (Honorary Contract Mersey Care)			

5.10 Services and interventions – all prisons

A table on services and interventions available to each prison is provided in Appendix 2. Table 10 gives a detailed breakdown on number of clinics held, as well as waiting times for health care and numbers of offenders on waiting lists. In terms of dental care, at the prisons where statistics were available, HMP Liverpool, Kennet and Styal, waiting times for routine care exceeded recommended

targets in the Department of Health's Strategy for Modernising Dental Services for Prisoners in England (Department of Health, 2003), which states that appointments for routine care should not exceed six weeks from the time of asking. Dental health among prisoners is worse than in the general population, due in part to oral neglect, often due to drug/alcohol problems or chaotic lifestyles of some offenders, combined with the effects on oral health of drug/alcohol use, smoking and poor nutrition (Harvey et al, 2005). On a national level, delivery of dental health care in prison is complicated by turnover of prison population, meaning it is sometimes impossible to complete courses of treatments, recruitment and retention of dental staff – issues around recruitment were mentioned in interviews with staff at HMP Kennet, leading to an increase in waiting times to see a dentist – and outdated facilities and equipment (Harvey et al, 2005).

In terms of waiting times for health care appointments outside the prison setting, prisoners in interviews mentioned anxiety around not knowing how long the wait would be for their appointment, and this was also identified by prison staff as a key reason for formal complaints from prisoners. However, security risks involved in prisoners knowing when they would be taken outside the prison meant that appointment dates could not be disclosed.

6. Probation population

The population covered by Merseyside Probation Trust includes district offices, approved bail hostels and unpaid work units. Merseyside Probation Trust service manages people who are on license, who have served sentences of more than 12 months, and those on community penalties, including suspended sentences, curfew, community orders, and specified activity such as the Turnaround project: the Liverpool Women's Turnaround Project, based at the Community Justice Centre in Kirkdale, aims to prevent families breaking down because of women being sent to jail. Authorities believe that because 70% of women inmates are serving a 12-month sentence or less, community-based support will deter re-offending[16].

Health care is delivered in a number of probation offices. At Old Swan and Kirkdale Probation Centres, nurses provide services including vaccination for Hepatitis A and B, wound management and mini mental health assessments, as well as signposting to other agencies. The 'Options' service, which works on the principle of 'bringing health care to the offender', is based at South Knowsley Probation Centre. It is the only full GP practice which operates in a probation office. A dedicated social worker works alongside nurses and GPs, as well as trained health and social care navigators, who are skilled in dealing with housing and employment issues, as well as providing signposting to other agencies. Options is commissioned by Knowsley Health and Wellbeing, and provided by Liverpool Community Health, to improve health among 'hard to reach' groups (Mimnagh, 2010). Currently, this is available for Knowsley residents only.

On 19th March 2012, Merseyside Probation Trust employed 190.45 FTE Probation Officers, and 101.99 FTE Probation Service Officers. Probation Service Officers work with offenders who present a low to medium risk of harm to others and have a lower risk of re- offending. In terms of wider health needs, ACHIEVE NW offers all offenders on Merseyside support with training/employment. Merseyside Probation Trust also operates a specialist accommodation unit for offenders, which links in with all key housing providers. More 'signposting' for offenders in terms of accessing support with wider health needs would be beneficial, however.

Data from Merseyside Probation Trust is provided in table 11 below. The data was taken from the IT system OASys[2]. The data shows numbers on the caseload[17] of Merseyside Probation Trust on 29th February 2012. A total of 7942 offenders were being supervised. 813 were female and 7129 were male. The data on health needs was compiled by asking offenders to answer a series of questions. For example, to measure alcohol need, offenders were asked questions about current and past alcohol use, violent behaviour related to alcohol use, motivation to tackle alcohol use etc. Responses were given a score, and, when offenders scored over a certain threshold, they were defined as having a need in that area, with which they would require support. For example, just over a quarter of offenders (223 female, and 1880 male) were defined as having an alcohol need[18]. Offenders scoring under the threshold for a health need often still required support from Probation Officers and Probation Service Officers, as well as signposting to other agencies. More detailed information about each district covered by Merseyside Probation Trust is provided in appendix 3. The voluntary sector provides a range of services for offenders, although this was outside the scope of this HNA.

16 (http://www.jmu-journalism.org.uk/#/news-386/4545645385: last accessed July 2011).

[2] OASys is the Offender Assessment System.

17 Caseload is the number of offenders who are being supervised by Merseyside Probation Trust at any one time.

18 Where offenders had a health need, this is shown as 'yes' on the table. 'No' means that the offender has been assessed, but did not have the need in question. N/A means that the offender was not assessed, due to the risk level of the offender or the particular sentence they had.

Table 11: Health needs, Merseyside Probation Trust

Alcohol need			
	Female	Male	Total
N/A	194	1390	1584
No	396	3859	4255
Yes	223	1880	2103
Grand Total	**813**	**7129**	**7942**
Employment, training and education need			
	Female	Male	Total
N/A	194	1389	1583
No	320	3094	3414
Yes	299	2646	2945
Grand Total	**813**	**7129**	**7942**
Accommodation need	**Gender**		
	Female	Male	Total
N/A	194	1389	1583
No	432	4042	4474
Yes	187	1698	1885
Grand Total	**813**	**7129**	**7942**
Drug need	**Gender**		
	Female	Male	Total
N/A	194	1389	1583
No	514	4723	5237
Yes	105	1017	1122
Grand Total	**813**	**7129**	**7942**
Drugs ever misused?	**Gender**		
	F	M	Total
N/A	189	1364	1553
No	198	1253	1451
Not Known	68	266	334
Yes	358	4246	4604
Grand Total	**813**	**7129**	**7942**
Domestic Status			
	Female	Male	Total
N/A	410	4107	4517
Married/Partner	41	372	413
Married/Partner/ Domestic Partnership	61	321	382
Not Known	54	549	603
Other	<5	135	N/A
Single/Div/Sep	147	1286	1433
Single/Div/Sep/ Domestic Partnership	96	359	455
Grand Total	**813**	**7129**	**7942**

Source: Merseyside Probation Trust, caseload 29th Feb 2012

7. Police custody population

There are eight Custody Suites across the Merseyside area. Six of these Suites, three of which are in Liverpool, two in Sefton, and one in St Helens, are operational 24 hours per day, 365 days per year. The other two Custody Suites, at Wavertree and Kirkby, are opened when required. During April 2011, a total of 5,531 people were arrested in Merseyside. On an average day in April 2011, 158 persons were arrested[19].

8. Interviews with key stakeholders

Between August and February 2012, a total of 58 interviews were carried out. 38 of these were with offenders, and 20 were with members of staff. 13 of the offenders that were interviewed in prisons and in the community were women, and 25 were men. 4 were young offenders aged 18-21. 22 interviews with prisoners were carried out. 3 interviews were carried out at HMP Liverpool, 6 at Altcourse, 8 at Kennet and 5 at Styal. Interviews at HMP Styal were only carried out with prisoners who were from the Merseyside area, and the majority of male prisoners interviewed were also from the Merseyside area. Interviews were also carried out with 10 members of health care staff in prisons.

Interviews were carried out with 16 offenders in the community. The majority were on probation, although some had been referred directly from the courts. We were unable to interview all professionals working with offenders, and decided to focus on treatment agencies such as Addaction and Mersey Care. Interviews were also conducted with staff at two projects aimed at female offenders, and with clients who attended these projects. Health care for offenders was organised differently across the 6 areas covered by Merseyside Probation, which meant that the way the interviews were organised was slightly different in each area. In Knowsley and St Helens, focus groups were carried out with offenders attending the Probation Service. Interviews were carried out with 8 members of staff working with offenders outside prisons.

Because of the large number of interviews being carried out, as well as issues around taking recording equipment into some of the prisons, interviews were not recorded, but notes were made by the researcher. Interviews lasted between 20 and 50 minutes. Interview schedules are provided in appendix 1.

8.1 Summary of findings

8.1.2 Joined up services for offenders

Many of the recommendations in this report relate to strengthening links between different health care providers. One of the most important links is between prison health care staff and those working in the community, in order to ensure smoother transition from prison to community health care, and also from community to prison. This is a recommendation which has been flagged up in previous reports, such as the 2009 Bradley Report (Department of Health, 2009), which looked at the needs of offenders with mental health problems and learning disabilities in the criminal justice system, and as a key recommendation stated that there should be greater continuity of care, when people enter and leave prison. On Merseyside, this might include a wide range of measures, including liaison between community and prison staff in terms of discharge planning, and timely notification of discharge from prison. This would also have the benefit of meaning that offenders had to go through a smaller number of assessments – both offenders and health care staff felt that offenders had to undertake a great deal of assessments, which might deter them from seeking help.

Many of these links are already in place, such as the meetings taking place between CARATS at HMP Liverpool in order to facilitate discharge planning, and liaison between health care staff working with offenders in police custody for Merseyside Police, and the mental health liaison team based at Liverpool Magistrates Court. Areas for improvement might include between hospitals and community staff: community treatment providers reported that they did not always know when their client has been in hospital, or to Accident and Emergency.

Another area where staff felt improvements could be made was around IT systems. Prison health care staff had to check two different IT systems, one detailing health care, and one which was used

[19] (Statistics received from Merseyside Police: May 2011).

by prison officers, which was time consuming and made it harder for health professionals to be confident that they had all appropriate information with regards to an individual in their care. Staff working with offenders in police custody also said that they would benefit from knowing more about offenders' health needs in terms of 'the bigger picture': it would be useful to know if they were keeping appropriate health appointments, e.g. with drug/alcohol treatment providers. This could be addressed by implementing SystmOne into custody suites, when responsibility for providing health care transfers to Merseyside Health Services, from April 2013. This would decrease the amount of assessments that offenders have to go through, saving the time of health care staff as well as being of benefit to offenders.

Health care staff reported that addressing the health needs of offenders with learning difficulties and learning disabilities was a problematic area. National research confirms this, showing that there are high numbers of offenders with unidentified learning difficulties or learning disabilities: the Prison Reform Trust (2007) estimated level of unmet need to be 32% within the criminal justice system. This could be addressed through assessment as soon as possible, for example when offenders arrive in prison, as well as by ensuring continuity of care for offenders through the criminal justice system as recommended in the Bradley Report (Department of Health, 2009), through strong links between different agencies or use of common IT systems throughout the criminal justice system, for example.

8.1.3 Prison health care

Concerns included the need to put in an 'application' to access health care. There was a perception among prisoners that this could lead to a delay in accessing health care. In addition, prisoners with low literacy levels reported difficulty in completing these forms, and having to rely on cell mates or prison officers to help complete them, which sometimes deterred them from asking for help. Other areas where prisoners and health care staff expressed dissatisfaction included transfer between prison and hospital. This necessitated using two prison officers, which could lead to a delay in emergency cases, and also resulted in embarrassment for offenders, who reported other patients staring at them as they were handcuffed to two prison officers.

Prisoners were also able to focus on themselves and their health care needs whilst in prison – outside prison, other needs, such as drug/alcohol addictions, may take priority. In prison, offenders were able to access health care quickly and easily, and had a lot of spare time in which to do it. They were able to focus on health problems including those that may have been masked by drug taking – for example prisoners were able to access dental care whilst outside prison dental pain would have been masked by drug use. Offenders who were determined to 'get clean' had a good opportunity to do so in this environment. However, offenders and health care staff inside and outside prisons did feel that drug use within prisons was a significant problem, with some respondents stating that drugs were easier to get hold of inside than outside prisons. The use of drugs at HMP Liverpool is an issue that has been highlighted in previous Board reports (Ministry of Justice, 2010) for HMP Liverpool. The report acknowledged that work had been done by management and staff to address this issue, but recommended that greater resources should be directed to assist in stopping the supply of drugs and tackling the addiction of many prisoners.

Medication was another issue which could result in a delay to delivery of adequate health care. There could be difficulties in getting the right medication, particularly at HMP Liverpool, which does not currently have an in-house pharmacy, although this is recommended for large prisons (NPC, 2012), and for those in police custody, where supplies of medication were more limited.

8.1.4 Health care for offenders in the community

In addition, health care staff and offenders, particularly those with drug/alcohol problems, reported that they would be more likely to use services in the community if they were all in one place. For example, in the past, Addaction, who are a criminal justice service working with drug/alcohol users in Liverpool, could provide methadone prescriptions etc for offenders, but also had a nurse attached to the service, so that offenders could have nursing treatment, such as dressing leg ulcers etc, at the same time as getting their prescriptions. Now offenders have to access nursing care elsewhere and they are less likely to access this care. Women using centres such as Tomorrow's Women Wirral, a project aimed at female offenders, where many services including benefits advice, job club, nursing care etc are provided under the same roof, are highly satisfied with care that they receive. Offenders may have a great deal of appointments to attend already, including with probation officers etc, and they may be more likely to access health care if it did not involve a large number of additional

appointments. In addition, this would cut down on the amount of time that health care staff spent 'chasing' offenders for appointments.

8.1.5 Female offenders and other vulnerable groups

For female offenders who were sent to prison, sentences tended to be shorter, but had a significant negative impact upon health. Although they were serving short sentences, women often lost accommodation whilst in prison, and in addition they were likely to lose residency of their children whilst in prison, and in the majority of cases never regained this after release. This was compounded by the fact that female offenders were held further from home. Staff reported that there was a perception among sentencers that sending women to prison would allow them to resolve any health issues, e.g. drug/alcohol problems, whilst in prison. However, short sentences meant that there was insufficient time for health care, such as drug/alcohol programmes etc, to be carried out, with the average sentence at HMP Styal being only 6 weeks.

Upon release many women did not feel comfortable with using treatment agencies, probation and hostels where women were in the minority. Where offenders' children were living with them, health care staff felt that female offenders might minimise any risk to children as a result of their lifestyles, as they were worried that raising concerns might mean that their children were taken away from them. Projects such as Tomorrow's Women Wirral, and Liverpool's Turnaround Project, where offenders are able to access many services such as advice about housing, jobs and benefits, assertiveness training etc 'under one roof' and in a safe environment appear to be effective in meeting health needs of female offenders. Specialist women's services exist in Liverpool, Sefton and Wirral, with plans to extend Turnaround to Knowsley. Merseyside Probation Trust has implemented a scheme to mitigate a lack of a dedicated women's service in St Helens.

8.1.6 Housing

It is apparent, both from the literature, and from interviews carried out with offenders and with health care staff, that housing is a central issue that impacts upon the health of offenders. There are many reasons for this. Offenders are likely to lose accommodation whilst in prison. For offenders who have had problems with drug dependency in the past, and have withdrawn from drugs whilst in prison, stricter environments, where drug use is not allowed, such as probation hostels, and environments where counselling is available, are most conducive to offenders not using drugs. However, this was often not the case, making it more difficult for ex-offenders to refrain from using drugs/alcohol. Offenders with drug and alcohol problems were also less likely to be able to access emergency housing provision: they are required to present themselves to housing providers at a particular time in order to access housing, but drug/alcohol issues made it difficult for them to do this on time, and accommodation was often already full by the time they arrived. In addition, some offenders were banned from hostels because of previous behaviour, e.g. violence towards staff, arson etc. There are particular issues around female offenders, who often don't feel comfortable using mixed hostel accommodation. Women tend to serve shorter sentences, meaning that there is less time to get accommodation arranged before discharge, but serving a short sentence can have a huge impact on their health if they lose their housing whilst in prison. A specialist accommodation unit within Merseyside Probation Trust, which links in with all key housing providers, helps to mitigate this.

8.1.7 Employment

Offenders who were being managed in the community, as well as those who had been discharged from prison, reported great difficulties in finding employment, particularly in the current economic climate. A major reason for this was the impact of having a criminal record. Interviewees reported that support in finding out which employers would be willing to employ someone with a criminal record would help: they were spending time on application forms and even interviews, only to be told that the particular employer did not accept applications from people who had a criminal record. Other barriers to employment included curfews, and conditions of client's licences preventing them from entering certain areas. ACHIEVE NW provides support into training and employment for offenders across the whole of Merseyside, more signposting is needed to available provision.

8.1.8 Needs of health care staff.

The needs of health care staff was another key issue that came out of the interviews, although due to the fact that relatively small numbers of staff were interviewed at each institution, it is not possible to break this section down by institution. A recommendation of this report would be for further research in this area. There was recognition among both offenders and health care staff that working within

certain environments, such as the prison environment, could often be very stressful for staff. This was exacerbated by the prison regimes, which could mean that nurses were waiting around while offenders were 'locked down', and by the need to access 2 different computer systems. High staff sickness rates and high staff turnover at some of the institutions was also resulting in additional stress for remaining staff. Several members of staff in prisons also felt that there could be a conflict between their caring role as a member of health care staff, and their security role.

Where incidents did arise, some health care staff in prisons reported that they did not always have the opportunity to debrief in the same way that prison officers would do, resulting in additional stress, although procedures are in place in Merseyside prisons stating that the debrief needs to happen. Staff development was also sometimes difficult where certain groups of staff were in a minority, e.g. RMNs in prisons, meaning that staff development pathways were not clear.

9. Discussion

Although interviews and focus groups were conducted with a diverse range of stakeholders, clear themes emerged. Many of the recommendations in this report relate to strengthening links between prison and community health care, to try to ensure a more smooth transition from prison to community health care, and also from community to prison health care. This includes a wide range of measures, from putting clients who have drug and alcohol problems onto continuous care packages, liaison between community and prison staff in terms of discharge planning, including timely notification of discharge from prison, and use of pathways such as the Community Prison Offender Passport. IT systems formed a large part of this – more appropriate, timely health care could be given where information about offenders health needs could be accessed online. Implementation of a common IT system, SystmOne, across Merseyside prisons had had a significant positive impact on health care. This could be improved further by implementing SystmOne into custody suites.

Most of the health care staff we spoke to felt that health care for offenders was available in most cases, if offenders were willing/able to use it, and most of the areas of priority that we identified were around access. In some cases, particularly for offenders with drug/alcohol problems, chaotic lifestyles of offenders prevented them from accessing services. Offenders were often unwilling/unable to wait for appointments, meaning that there is a need for drop-in clinics, and provision of health care 'under one roof' where possible. This was available in some areas, e.g. the Options service offers access to a range of health professionals including GPs, nurses, and social workers, as well as health care navigators who help address wider health needs. However, this provision needs to be more consistent across Merseyside. Other issues that might deter offenders from using services included other offenders that they might come into contact with, including those who they felt might encourage them to continue to use, or restart use of, drugs and/or alcohol.

Offenders and members of health care staff were generally positive about prison health care. Suggested improvements were primarily around access to health care – many offenders mentioned that having to complete 'applications' for health care could deter people from seeking help. Prisoners with low literacy levels may need to rely on help from other inmates or from prison officers to complete these, which might put them off completing applications for certain health conditions that they did not want to share with others. Offenders should also have the option of receiving health care on prison wings, as well as at health care centres. Dental health care was another area of priority concern, with offenders in all Merseyside prisons waiting longer than recommended in national guidelines for routine dental care.

In terms of drug use, several offenders stated that, if someone was determined to get off drugs, then being in prison was an ideal opportunity to do this. Several offenders mentioned that being sent to prisons where they did not know other offenders had actually been beneficial in terms of being able to withdraw from drugs. However, for offenders who were less motivated to withdraw from drugs, access to drugs inside prison appeared to be a significant issue.

As has been observed by authors in other settings, prevalence rates of health issues recorded on SystmOne for Merseyside prisons are lower than would be expected, when compared to national prevalence rates. Rates for blood borne virus recorded at Merseyside prisons, for example, seem particularly low. This is due in part to the fact that SystmOne is a relatively new system, and is still being rolled out to prisons at the time of this report going to press. For this reason, this health needs assessment has included national prevalence data as well as any local data available. Had more

robust local data been available, it might have been possible to make more sophisticated recommendations for each prison based on prevalence data. Other issues that have been problematic following the introduction of SystmOne include the fact that health issues have been coded differently across the Merseyside prisons, although a member of staff will have responsibility for addressing coding issues across the Merseyside prisons, which should help to address this issue.

A new Hepatitis C service that was introduced at HMP Liverpool, Altcourse and Kennet in 2011 ensures active engagement of staff with promoting Hep C awareness, and is a Specialised Secondary Service, which is normally delivered in a hospital, but is now delivered by the same secondary care staff in a prison setting.

In terms of wider health needs, accommodation and employment were raised several times as key concerns, both for those in prison and on probation. When offenders leave prison, appropriate accommodation and employment can have an impact on re-offending behaviour. According to a Home Office Report, two thirds of offenders commit a crime within two years of release from prison (Berman, 2012). In a speech in September 2005, the Home Secretary highlighted the need to reduce re-offending by improving their employability, as well as other measures including addressing drug and alcohol problems[20]. For example, offenders with drug and alcohol problems reported in interviews that bail hostels that they were sent to following discharge from prison often made it harder for them to stay free from drugs/alcohol, as drugs were readily available in some hostels. Employment was also raised as a key issue. Following discharge from prison in particular, having a criminal record was a significant barrier to finding appropriate employment, particularly in the current economic climate. Support in finding employment and access to appropriate training was patchy across Merseyside. In terms of training and skills needed for employment, many offenders, particularly female, mentioned the need for assertiveness skills/confidence etc before they felt they were able to work.

Changes to The Work Programme in Spring 2012 will mean that offenders who miss appointments will have their benefits stopped (http://www.direct.gov.uk/en/Employment/Jobseekers/programmesandservices/DG_197781). This is likely to have a great impact on offenders, many of whom have chaotic lifestyles due to drug/alcohol problems etc. This could also lead to difficulties in paying for accommodation, which in turn links in to reoffending etc.

Benefits advice was another area where improvements could be made. Particularly where offenders had been sent to prison for short sentences (which applied more to female offenders), benefits were not fully in place by the time someone was discharged from prison. In some cases, offenders had only just got benefits sorted out from a previous admission to prison, when they were sent back to prison. Planning for benefits/accommodation etc on release needs to start as soon as possible after someone arrives in prison.

Several female offenders mentioned that they would not feel comfortable using services, particularly drug/alcohol services and hostel accommodation, that was used by male offenders, and this was reiterated by the health care workers who looked after female offenders. Many of these women had a history of abuse etc themselves and would not be comfortable sharing accommodation with male offenders who they may perceive to be violent etc. Female offenders and health care staff highly rated provision that was specifically targeted at women, e.g. Tomorrow's Women Wirral etc, where they could get all their health needs met 'under one roof'. Staff and female offenders also mentioned the importance of being able to get basic needs met – they were able to get meals at Tomorrow's Women Wirral, for example, and to use the washing machine in order to keep their clothes clean.

For female offenders, these projects had a far more beneficial impact on their health than being sent to prison. One of the most important factors was that they were able to keep their families together: research shows the majority of female offenders who are sent to prison lose residency of their children, and in 90% of cases never regain this. Many of these children are taken into the care of the local authority. Because sentences given to women are shorter than those given to male offenders, there is less time for offenders to get accommodation sorted out before discharge. Health care staff who worked with female offenders felt that there was a perception among sentencers that female

[20] (http://press.homeoffice.gov.uk/Speeches/09-05-sp-prison-reform).

offenders might benefit from a prison sentence in order to address health problems, but the reality in terms of families being broken up is very different, particularly as female offenders tend to be held further away from home than male offenders. There are no female prisons on Merseyside, so female offenders are sent some considerable distance to HMP Styal, or even further away in some cases. Where female offenders were sent to projects such as Tomorrow's Women Wirral, they were able to access a wide range of services under one roof (including assertiveness training, confidence building, benefits advice etc. In terms of future provision, there should be a Women's Strategy in all areas. Currently, specialist women's services are available in Liverpool, Sefton and Wirral, with plans to roll services out to Knowsley. Probation has implemented a scheme to mitigate a lack of a dedicated women's service in St Helens. A recommendation of this report would be for specialist services for female offenders to continue to be available throughout Merseyside.

The use of Conditional Cautions to offenders residing in Liverpool and Birkenhead has had a success rate of 80%. During 2011/12, 80 women received conditional cautions for a range of offences, 66% of which involved shoplifting and 14% possession of drugs, with a condition to attend either Together Women, a community-based intervention which aimed to reduce re-offending among female offenders and address the needs of women 'at risk' (Ministry of Justice, 2011b), or the Turnaround Project[21], which provides support for female offenders or those at risk of offending. Out of the 80 cases, only 17.3% re-offended, with a breach in only one case, equating to a success rate of 80%. One recommendation of this report would be to look at the feasibility of rolling out this service to Sefton, St Helens and Knowsley.

Other issues included reluctance to take up health services e.g. screening, where offenders felt that they had to attend, e.g. as a condition of their licence. Offenders who had children living with them, particularly female offenders, might feel the need to play down any problems, because of the fear that they might have their children taken away from them. A proportion of female offenders were also street workers, who were sometimes reluctant to address health concerns for fear of getting into trouble with the police etc. Also in general, several offenders mentioned the fact that they did not feel entitled to ask for help, particularly with regards to wider health needs such as accommodation etc, as their situation with self-inflicted. These issues could be alleviated to some extent once health care providers had established a rapport with offenders, as well as liaison with social services etc where appropriate.

Housing was a particular area of concern for this client group, particularly those with drug/alcohol problems. One member of health care staff felt that increased funding for hostels etc, and using very experienced members of staff to run them, might help to alleviate the issues around having to exclude certain groups of offenders, as well as problems around drugs being available in the hostels. However, staff were also aware that a steep increase in funding for housing of offenders might not be possible in the current economic climate. A specialist accommodation unit provided by Merseyside Probation Trust, which links in with key housing providers, helped to mitigate this, and many treatment providers also had strong links with agencies providing housing. A related, important issue, was the use of IT systems. Health care staff in prisons and police custody had to use two different computer systems, with different information again being kept by Merseyside Probation Trust, and a range of other agencies. If computer records could somehow be linked, and could contain information about offenders who were on certain packages, then health care staff time would be saved in assessing offenders, offenders would have to go through less assessments, and more timely, appropriate health care could be provided.

These recommendations echo those published in the Bradley Report (Department of Health, 2009), which emphasised the importance of continuity of care for those entering prison and being released from prison, especially those who have mental health problems or learning disabilities. The Bradley Report also emphasised the importance of prevention and early intervention for vulnerable groups in the criminal justice system, which would include intervention by looking at wider health needs such as accommodation and employment. Bradley also emphasised the importance of prevention and early intervention for young people in the criminal justice system, which will be addressed in a health and well-being needs assessment for young offenders which will be published in December 2012.

[21] (http://www.merseysideprobationtrust.gov.uk/news/default_item.php?id=158).

Because health care was organised differently in each of the 4 prisons that we went into, as well as in each of the areas covered by Merseyside Probation, there was some disparity in provision. Additional 'signposting' was necessary, so that offenders knew where to go to access support with finding appropriate employment and training opportunities.

In April 2012, Department of Health ministers agreed that a number of topics would be referred to NICE, the National Institute for Health and Clinical Excellence, which provides national guidance on promoting good health. These included public health guidelines on the effectiveness and cost-effectiveness of interventions for prevention and early detection of mental health problems among those in the criminal justice system, as well as joint clinical guidelines and public health guidance on ensuring prisoners have full and appropriate access to effective and cost-effective care for both physical and mental health problems. NICE guidelines take between six months and two years to produce, and this health needs assessment will need to be reviewed following publication of this guidance.

Because the scope of this health needs assessment was quite broad, covering the whole of the criminal justice system across Merseyside, and involved interviews with a wide range of stakeholders, including health care staff working in prisons and in the community, numbers of people interviewed at each institution were relatively low. Recommendations that are specific to each institution have only been made where there is quantitative data or other evidence to substantiate them, and where it is possible to do this without identifying those who took part in the interviews. In addition, as demonstrated in the literature review[22], wider health needs, including accommodation and training/employment, are key to offending behaviour, including preventing re-offending. We decided to focus on health care staff in prisons for this health needs assessment. However, interviews/focus groups with CARATS staff/accommodation teams in prisons, as well as their equivalents in the community, would help to identify key issues with regards to addressing wider health needs of offenders on Merseyside.

[22] (http://press.homeoffice.gov.uk/Speeches/09-05-sp-prison-reform).

10. Recommendations

The following recommendations have been produced based upon the national and local evidence, as well as best practice of what is effective in improving the health and wellbeing of offenders.

10. 1 Core recommendations

- All core recommendations should be implemented by Merseyside Offender Health and Social Care Board.
- Link up computer systems detailing health needs of offenders. The EMIS system should be accessible to all prisons. When responsibility for providing health care in custody suites transfers to Merseyside Health Services in 2013, SystmOne should be available to custody health staff.
- Also in relation to IT systems, coding needs to be done in a systematic way across prisons. The appointment early in 2012 of a system manager, who will work across all 3 Merseyside prisons, will help to facilitate this.
- Maintain and strengthen links between, as well as within, different agencies working with offenders. When full data is available on outcomes later in 2012, commissioners should consider rolling out the Community Prison Offender Passport (see appendix 4), to all Merseyside offenders. The passport helps to promote continuity of care and to identify and address a range of health needs including wider health needs.
- Ensure health care for offenders is easily accessible. Provide drop-in clinics, rather than expecting offenders to wait for appointments, and provide services 'under one roof' where possible. Look into the cost-effectiveness of rolling out the Options service, which is based at South Knowsley Probation Centre, or similar, across the whole of Merseyside.
- Provide 'female only' services, to ensure that female offenders are able to access services that meet their specific needs in a non-threatening environment.
- Ensure needs of health care staff working with offenders are addressed, including needs in terms of staff development, and debriefing/ongoing support.
- Assess the health needs of the ageing population of offenders, and respond with health care that is appropriate to the age profile of the population.
- Maintain a register on number of offenders with disabilities, both in prison and in the community.
- If more detailed recommendations are required for each institution, then a greater number of interviews will need to be carried out in each institution.
- Conduct interviews with staff including CARATS team, accommodation teams etc, to get a better understanding of these issues and their impact on offending behaviour.
- When Offender Health functions transfer to the National Commissioning Board (NCB) from April 2013, and Clinical Commissioning Groups (CCG) become responsible for offenders who are in contact with the criminal justice system, strong links will need to be developed between the NCB and CCGs.
- Review this HNA once all new structures described above are in place.
- Reviews this health needs assessment following publication of NICE guidelines on the effectiveness and cost-effectiveness of care for mental and physical health problems among prisoners, and of NICE public health guidance for addressing mental health problems for those in the criminal justice system. These topics were referred to NICE in April 2012.
- Consider if we need a North West offender approach. At the very least, offender health care should be delivered on a Merseyside footprint.

10.2 Recommendations for prisons

- Ensure that health care is accessible. Difficulties in filling in 'applications' to access health care, coupled with difficulties caused by the prison regime may mean that health care is harder to access. Offer the option of health care on prison wings.
- Ensure that dental problems are treated prior to discharge from prison. Keep waiting for dental care to a minimum.
- Address issues around drug use among prisoners.
- Address the needs of health care staff working in prisons, including the need to debrief following incidents, the impact of prison regimes on health care, and staff development,

particularly where there are small numbers of staff working in an institution, in order to reduce sickness absence rates and staff turnover.

- Ensure that numbers of prisoners with disabilities is recorded consistently across Merseyside prisons.
- Provide health care that is appropriate for the ageing prison population.
- Consider end of life care when planning prison health care, using MacMillan Cancer Support prison standards where appropriate[23]

10.3 Recommendations for HMP Liverpool

- Look at adapting cells in the future to accommodate wheelchairs.
- Issues around timely dispensation of medication could be alleviated by providing an in-house pharmacy (NPC, 2012).
- At the end of 2012, assess the impact of HMP Liverpool receiving prisoners from courts outside Liverpool. Merseyside Offender Health and Social Care Board to assess to ensure adequate health care staff are in place. Prison health care staff to look at any additional capacity and security issues.

10.4 Recommendations for HMP Altcourse

- Chronic disease should be captured as a register, in line with other Merseyside prisons.

10.5 Recommendations for HMP Styal

- Assess physical resources available for health care. Many of the facilities were built some years ago, making delivery of effective health care more challenging.
- Ensure liaison with appropriate professionals in advance of women being discharged back to the Merseyside area.

10.5 Recommendations for Merseyside Probation Trust

- Focus on wider health, with adequate 'signposting' to agencies who can support offenders. Consider use of the Community Prison Offender Passport (see appendix 4), which includes questions about accommodation and employment needs, as well as financial planning, where cost-effective.
- Review data from relatively new women's projects, such as Tomorrow's Women Wirral and the Turnaround Project, when at least a year's worth of data is available.
- Continue to roll out the above projects across Merseyside.

10.5 Wider health needs – recommendations

- Focus on wider health needs including accommodation, employment and financial planning, with adequate 'signposting' to agencies who can support offenders.
- The landscape with regards to employment support, such as The Work Programme, is changing, and the impact on offenders of these changes should be monitored.

10.6 Recommendations for sentencers

- Look at alternatives to prison for wherever appropriate, in line with recommendations from the Bradley Review (Department of Health, 2009), saving up to 2,000 prison places per year.
- Consider rolling out Conditional Cautions for women, which are currently used for offenders residing in Liverpool and Birkenhead, to all women on Merseyside.

[23] (http://www.endoflifecareforadults.nhs.uk/case-studies/a-new-set-of-standards-for-end-of-life-care-in-prisons).

11. Conclusion

In conclusion, although the HNA was very broad, a number of clear themes emerged. These included the need for services for offenders to be easy to access, and to be appropriate for the groups of offenders that they were aimed at, e.g. female offenders were generally more likely to access projects aimed specifically at women. The need to maintain and strengthen links between different providers and agencies working with offenders is also clear. The environment in which offender health care is being delivered is rapidly changing, with the abolition of Primary Care Trusts from April 2013, and the establishment of new structures, along with changes being made by the Government such as changes to The Work Programme, mean that ongoing evaluation of offender health care is vital. The new structures may also provide increased opportunities for offender health care to be planned and implemented on a Merseyside-wide footprint.

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13. Appendices.

Appendix 1 – Interview schedules

Interviews with prisoners

Date of interview.....

Prison HMP
- Liverpool ☐
- HMP Altcourse ☐
- HMP Kennet ☐
- HMP Styal ☐

Status
- Remand ☐
- Sentenced ☐

Length of sentence
- More than 12 months ☐
- Less than 12 months ☐

Category B ☐ C ☐ D ☐

Age
- 18-29 ☐
- 30-39 ☐
- 40-49 ☐
- 50-59 ☐
- 60 + ☐

Gender
- Male ☐
- Female ☐

Ethnic group
- White British, Irish or other White background ☐
- Mixed ☐
- Asian – Indian, Pakistani, Bangladeshi, Other Asian ☐
- Black or Black British ☐
- Chinese or other ethnic group ☐

How is your health? Any health problems? If so which are the health problems that cause you the most concern? Which health services in the prison do you use in prison?

Are you able to get all the health care that you need in prison? If not, possible reasons why? Are there certain health issues that you are less likely to seek help for? Discuss wider health needs including accommodation, employment etc.

What are your feelings about the quality of health services in prisons? How could these be improved?

How commonly do you access advice on issues such as diet, exercise, smoking, sexual health, alcohol, etc? How could these services be improved?

Before you were in prison, did you always seek help for the health problems? If not, possible reasons why? Were there certain health issues that you were less likely to seek help for?
Did you have a GP before in the 12 months you were in custody? YES/ NO
If YES, was this an NHS or a private dentist?
Did you have a dentist in the 12 months before you were in custody? YES/NO

If you have left prison before, were there issues with accessing healthcare on leaving prison? What would have helped you to get the health care that you needed?
Any other comments about health care in prison or outside prison?

Interviews with health care staff in prisons

Do you feel that offenders always seek help for their health problems whilst in prison?

Are their certain health issues that prisoners are less likely to seek help for?

What are your feelings about the quality of health services used by offenders?

How could the quality of health care offered to offenders be improved?

What is the quality of transfers between prisons? How could this be improved?

What is the quality of transfer from prison to hospital, when necessary?

What is the quality of preventive health services such as diet, smoking, exercise, sexual health, alcohol etc? How could these be improved?

Do you feel that offenders seek help for health problems prior to being in custody?

Do you feel that offenders seek help for all their health needs following discharge? How could this process be improved?

Any other issues?

Interviews with offenders in the community

Date of interview.....

Probation area	Liverpool	☐
	Sefton	☐
	Knowlsey	☐
	St Helens	☐
	Wirral	☐

Recruiting organisation .....

Age	18-29	☐
	30-39	☐
	40-49	☐
	50-59	☐
	60 +	☐

Gender	Male	☐
	Female	☐

Ethnic group	White British, Irish or other White background	☐
	Mixed	☐
	Asian – Indian, Pakistani, Bangladeshi, Other Asian	☐
	Black or Black British	☐
	Chinese or other ethnic group	☐

How is your health? Any health problems? If so which are the health problems that cause you the most concern? Do you have any long-term illness, health problem or disability which limits your daily activities or the work that you can do?

Do you have a GP? YES/ NO
Do you have a dentist? YES/NO
How easy is it access the GP and dentist? How could this service be improved?

Which health services do you use (e.g. drug and alcohol treatment services, mental health services etc)?

What are your feelings about the quality of health services (e.g. drug and alcohol treatment services, mental health services etc) that you use now that you are on probation? How could these services be improved?

Are you able to get all the health care that you need? If not, possible reasons why? Are there certain health issues that you are less likely to seek help for? (Discuss wider health needs such as accommodation, employment etc as part of this).

Before you were on probation, were you able to get all the health care that you needed? Were there certain health issues that you were less likely to seek help for?

If you have been in prison, how easy was it to get the health care that you needed in prison? What did you think about the quality of health care in prisons? How could this be improved?

If you have left prison, how easy was it to get all the health care that you needed when you left (discuss wider health needs such as accommodation, employment etc as part of this). How could this process be improved? Is there any support that could be put in place that would have made this transition easier?

Interviews with health care staff in the community

Do you think there is a link between offending and health?

What kind of health services do offenders most commonly use?

Do you feel that offenders always seek help for their health problems? If not, are their certain health issues that offenders least likely to seek help for?

How commonly do offenders access advice on issues such as diet, exercise, smoking, sexual health, alcohol, etc?

Are you aware of any problems encountered by offenders in accessing health services?

What are your feelings about the quality of health services used by offenders? Are there any specific issues around quality?

Do you feel that the current provision is meeting the health care needs of offenders? If not, how could this be improved? *(include all issues not covered by the questions above).*

Table 12: Services and interventions

		Liverpool	Altcourse	Kennet	Styal
	GP				
	How many GP clinics were held?	Reception clinics variable. Minimum GP clinics 40 per month	Total 922. Average 2.7 per day.	Reception clinics variable.	179
	How many offenders were seen by the GP?	Minimum 480 per month	Total 10452. 950. Average per month	216 average per month	1821
	How many offenders failed to keep their GP appointment?	57 average per month	Total 153. Average 14 per month	57 average per month	406
	Nurse led clinics				
	How many nurse led clinics were held?	Clinics offered daily 275 average per month	Total 1219 Average 111 per month	Clinics offered daily.	554
	How many offenders on Chronic Disease Register	308	Not available	199	120
	Dentist				
	How many clinics were held?	8 per week	Total 201. Average 18.3 per month, 4.2 per week	2 per week	N/A
	How many offenders were seen?	77 average per month	Total 2382. Average 216.5 per month	49 average	N/A
	How many offenders failed to attend?	54 average per month	Total 360. Average 32.7 per month	6 average per month	N/A
	Optician				
	How many clinics were held?	1 per week	Total 12. Average 1.1 per month	1 alternate weeks	18
	How many offenders were seen?	7 per session (28 per month)	Total 356 were offered appointments. Average 32.4 per month	29 per month on average	133
	How many offenders failed to attend?	N/A	5.1 per month	6 average per month	59
	Chiropodist/ Podiatrist				
	How many clinics were held?	1 per month	Total 12, average 1.1 per month	2 per month	External
	How many offenders in current group?	17 in November 2011	18 offered appointments in Nov 2011	15 per month on average	N/A
	How many offenders failed to attend?	4 in November 2011	4 failed to attend Nov 2011	6 per month on average	N/A
	Physiotherapist				
	How many clinics were held?	2 per week	4.3 per month	1 per week	External
	How many offenders were seen?	32 average per month	Average 43.7 offered, average 9.2 DNA; average 34.5 seen	23 average per month	N/A
	How many failed to attend for their appointment?	9 average per month	9.2 average per month	6 average per month	N/A
	Primary Care Mental Health				
	How many first contact/ new admissions were seen?	350 (29.2 average per month) *	Average 103 per month	Average 8-10 per month	N/A
	How many routine assessments/ referrals were	2422 (201.8	209 average per	49 average	N/A

	seen?	monthly average) *	month	per month	
	How many ACCT referrals were seen? Patient Count	25	21.6 average per month	3 average per month	N/A
	How many offenders were seen on Rule 45 Reviews in CSU?	N/A	37.8 average per month	NIL	N/A
	Mental Health In-Reach				
	How many offenders were seen for an initial mental health assessment	153 (12.7 average per month) *	17.7 average per month	N/A (no in-reach at Kennet)	994
	How many offenders from primary care referral fall under in-reach?	153*	N/A	N/A	N/A
	How many offenders were identified as suitable for transfer under the MHA?	7* (0.6 average per month)	2.4 average per month	N/A	N/A
	How long have offenders been waiting for transfer?			N/A	N/A
	2 weeks or less	7*	21	N/A	N/A
	3-4 weeks	0	<5	N/A	N/A
	5-8 weeks	0	<5	N/A	N/A
	9-12 weeks	0	<5	N/A	N/A
	13-20 weeks	0	0	N/A	N/A
	20 weeks or more	0	0	N/A	N/A
	How many offenders transferred out under the MHA?	7* (0.6 average per month)	15 (1.4 average per month)	None	N/A
	How many offenders returned from custody from a mental health section?	4*	<5	None	N/A
	Other Psychological Services				N/A
	How many new referrals were received by Counsellors?	350 (29.2 average per month) *	561 (56 average per month)	Average 3 per month	N/A
	What is the current case load of the Counsellors' Team?	77 (Nov 2011)*	76 (Nov 2011)	Approx 24 per month	N/A
	Substance Misuse Services				
	How many clients were assessed for substance misuse support services?	829 (69.1 average per month)*	1026 (93.3 average per month)	Average 8-10 per month	1310[24] (average 109 per month)
	How many offenders were on clinical treatment at month end?	210*	1845 (average 167 per month)	31	N/A
	How many commenced methadone programme?	815 (67.9 average per month)*	670 (60.9 per month)	25	560 (46.6 per month) [25]
	How many commenced buprenorphine programmes?	0*	11 (average 0.5 per month)	Nil	20 (average 1.7 per month) [26]
	How many commenced a detoxification project?	N/A	20.1 monthly average detoxed for methadone 29.9 monthly average detoxed for alcohol 12.4 monthly average for diazepam	15 monthly average	N/A
	How many commenced a maintenance programme?	N/A	491 (44.6 average per month)	10 average per month	N/A
	How many offenders were discharged from the clinical programme having completed their treatment?	N/A	262 (23.8 average per month)	1-2 average per month	N/A

[24] 1st Nov 2010 to 31st Oct 2011
[25] 1st Nov 2010 to 31st Oct 2011
[26] 1st Nov 2010 to 31st Oct 2011

		Liverpool	Altcourse	Kennet	Styal
	Dentist				
	How many offenders are currently on the waiting list?	72	N/A	69	None
	What was the average waiting time for first appointment?	Urgent – no wait Routine – 3 months	N/A	Urgent – no wait Routine – 2 months	2 months
	How many clinics were held?	N/A	201 (average 18.3 per month)	N/A	N/A
	How many dental appointments were offered?	N/A	2601 (236 average per month)	N/A	N/A
	How many offenders were seen by the dentist for:	N/A	N/A	N/A	N/A
	Level 1 treatment (examination/diagnosis/preventive care)	N/A	930 (84.5 average per month)	N/A	N/A
	Level 2 treatment (fillings/extractions/ urgent root canal)	N/A	1126 (102.4 average per month)	N/A	N/A
	Level 3 treatment (crowns/dentures/bridges)	N/A	326 (29.6 average per month)	N/A	N/A
	How many offenders failed to attend?	N/A	360 (32.7 average per month)	N/A	N/A
	Opticians				
	How many offenders are currently on the waiting list?	40	N/A	Nil	35
	What was the average waiting time for first appointment?	4 weeks	N/A	2 weeks	2 months
	How many clinics were held?	N/A	11 (average 1.1 per month)	N/A	N/A
	How many offenders were offered appointments?	N/A	356 (average 32 per month)	N/A	N/A
	How many offenders failed to keep their appointment?	N/A	56 (average 5.1 per month)	N/A	N/A
	Chiropodist/podiatrist				N/A
	How many offenders are currently on the waiting list?	0	60 (average 5.4 per month)	Nil	N/A
	What was the average waiting time for first appointment?	1 month	N/A	2 weeks	N/A
	Smoking cessation				
	How many offenders are currently on the waiting list?	40	N/A	Nil	None
	What was the average waiting time for first appointment?	4 weeks	N/A	1 week	1 week
	Physiotherapist				
	How many offenders are currently on the waiting list?	<5	N/A	1	N/A
	What was the average waiting time for first appointment?	1 week	N/A	2 weeks	N/A
	How many appointments were offered to offenders?	N/A	481 (average 43.7)	N/A	N/A
	How many offenders failed to attend for their appointments?	N/A	101 (average 9.2)	N/A	N/A

Source: HMP Liverpool, Altcourse, Kennet and Styal. HMP Liverpool and Kennet 1st Nov 2010 to 31st Oct 2011, HMP Altcourse 1st Jan 2011 to 31st Nov 2011, HMP Styal 1st April 2011 to 31st Oct 2011, unless otherwise stated.

* employed by Merseycare

Appendix 3: Statistics on health need from Merseyside Probation Trust

Table 13*: Health needs, Knowsley*

Alcohol Need	Gender		
	F	M	Total
N/A	21	178	199
No	45	548	593
Yes	19	198	217
Grand Total	**85**	**924**	**1009**
Employment, training or education Need	**Gender**		
	F	M	Total
N/A	21	178	199
No	32	389	421
Yes	32	357	389
Grand Total	**85**	**924**	**1009**
Accommodation Need	**Gender**		
	F	M	Total
N/A	21	178	199
No	49	533	582
Yes	15	213	228
Grand Total	**85**	**924**	**1009**
Drug Need	**Gender**		
	F	M	Total
N/A	21	177	198
No	57	615	672
Yes	7	132	139
Grand Total	**85**	**924**	**1009**
Drugs ever misused?	**Gender**		
	F	M	Total
N/A	21	175	196
No	21	145	166
Not Known	<5	20	N/A
Yes	39	584	623
Grand Total	**85**	**924**	**1009**
Domestic Status	**Gender**		
	F	M	Total
N/A	26	414	440
Married/Partner	<5	79	82
Married/Partner/ Domestic Partnership	17	76	93
Not Known	8	92	100
Other	N/A	9	N/A
Single/Div/Sep	15	157	172
Single/Div/Sep/ Domestic Partnership	16	97	113
Grand Total	**85**	**924**	**1009**

Source: Merseyside Probation Trust, caseload 29th February 2012

Table 14: Health needs, North Liverpool

Alcohol Need	Gender		
	F	M	Grand Total
N/A	36	242	278
No	124	1022	1146
Yes	65	423	488
Grand Total	**225**	**1687**	**1912**
Employment training or education need	**Gender**		
	F	M	Grand Total
N/A	36	242	278
No	91	768	859
Yes	98	677	775
Grand Total	**225**	**1687**	**1912**
Accommodation Need	**Gender**		
	F	M	Grand Total
N/A	36	242	278
No	127	1045	1172
Yes	62	400	462
Grand Total	**225**	**1687**	**1912**
Drug Need	**Gender**		
	F	M	Grand Total
N/A	36	242	278
No	137	1184	1321
Yes	52	261	313
Grand Total	**225**	**1687**	**1912**
Drugs ever misused?	**Gender**		
	F	M	Grand Total
N/A	33	235	268
No	47	264	311
Not Known	27	71	98
Yes	118	1117	1235
Grand Total	**225**	**1687**	**1912**
Domestic Status	**Gender**		
	F	M	Grand Total
N/A	159	1235	1394
Married/Partner	7	40	47
Married/Partner/ Domestic Partnership	<5	15	16
Not Known	14	97	111
Other	<5	8	9
Single/Div/Sep	36	269	305
Single/Div/Sep/ Domestic Partnership	7	23	30
Grand Total	**225**	**1687**	**1912**

Source: Merseyside Probation Trust, caseload 29th February 2012

Table 15: Health needs, South Liverpool

Alcohol Need	Gender		
	F	M	Total
N/A	52	420	472
No	58	841	899
Yes	28	307	335
Grand Total	**138**	**1568**	**1706**

Employment training or education need	Gender		
	F	M	Grand Total
N/A	52	419	471
No	43	571	614
Yes	43	578	621
Grand Total	**138**	**1568**	**1706**

Accommodation Need	Gender		
	F	M	Grand Total
N/A	52	419	471
No	64	764	828
Yes	22	385	407
Grand Total	**138**	**1568**	**1706**

Drug Need	Gender		
	F	M	Grand Total
N/A	52	420	472
No	77	936	1013
Yes	9	212	221
Grand Total	**138**	**1568**	**1706**

Drugs ever misused?	Gender		
	F	M	Grand Total
N/A	51	413	464
No	28	207	235
Not Known	7	70	77
Yes	52	878	930
Grand Total	**138**	**1568**	**1706**

Domestic Status	Gender		
	F	M	Grand Total
N/A	125	1463	1588
Married/Partner	N/A	18	18
Married/Partner/ Domestic Partnership	<5	6	7
Not Known	<5	17	18
Other	<5	9	10
Single/Div/Sep	7	45	52
Single/Div/Sep/ Domestic Partnership	<5	10	13
Grand Total	**138**	**1568**	**1706**

Source: Merseyside Probation Trust, caseload 29th February 2012

Table 16: Health needs, Sefton

Alcohol Need	Gender		
	F	M	Grand Total
N/A	31	234	265
No	46	527	573
Yes	32	249	281
Grand Total	**109**	**1010**	**1119**
Employment training or education need	**Gender**		
	F	M	Grand Total
N/A	31	234	265
No	47	462	509
Yes	31	314	345
Grand Total	**109**	**1010**	**1119**
Accommodation Need	**Gender**		
	F	M	Grand Total
N/A	31	234	265
No	57	552	609
Yes	21	224	245
Grand Total	**109**	**1010**	**1119**
Drug Need	**Gender**		
	F	M	Grand Total
N/A	31	234	265
No	67	645	712
Yes	11	131	142
Grand Total	**109**	**1010**	**1119**
Drugs ever misused?	**Gender**		
	F	M	Grand Total
N/A	31	230	261
No	34	206	240
Not Known	<5	38	N/A
Yes	41	536	577
Grand Total	**109**	**1010**	**N/A**
Domestic Status	**Gender**		
	F	M	Total
N/A	32	290	322
Married/Partner	9	102	111
Married/Partner/ Domestic Partnership	11	80	91
Not Known	16	177	193
Other	<5	33	N/A
Single/Div/Sep	23	276	299
Single/Div/Sep/ Domestic Partnership	17	52	69
Grand Total	**109**	**1010**	**N/A**

Source: Merseyside Probation Trust, caseload 29th February 2012

Table 17: St Helens

Alcohol Need	Gender		
	F	M	Grand Total
N/A	11	56	67
No	49	269	318
Yes	23	241	264
Grand Total	**83**	**566**	**649**

Employment training or education need	Gender		
	F	M	Grand Total
N/A	11	56	67
No	31	256	287
Yes	41	254	295
Grand Total	**83**	**566**	**649**

Accommodation Need	Gender		
	F	M	Grand Total
N/A	11	56	67
No	49	340	389
Yes	23	170	193
Grand Total	**83**	**566**	**649**

Drug Need	Gender		
	F	M	Grand Total
N/A	11	56	67
No	65	406	471
Yes	7	104	111
Grand Total	**83**	**566**	**649**

Drugs ever misused?	Gender		
	F	M	Grand Total
N/A	11	56	67
No	17	126	143
Not Known	12	17	29
Yes	43	367	410
Grand Total	**83**	**566**	**649**

Domestic Status	Gender		
	F	M	Grand Total
N/A	19	202	221
Married/Partner	7	49	56
Married/Partner/ Domestic Partnership	15	51	66
Not Known	8	90	98
Other	N/A	15	N/A
Single/Div/Sep	19	112	131
Single/Div/Sep/ Domestic Partnership	15	47	62
Grand Total	**83**	**566**	**649**

Source: Merseyside Probation Trust, caseload 29th February 2012

Table 18: Health needs, Wirral

Alcohol Need	Gender		
	F	M	Grand Total
N/A	39	254	293
No	68	588	656
Yes	45	412	457
Grand Total	**152**	**1254**	**1406**
Employment training or education need	**Gender**		
	F	M	Grand Total
N/A	39	254	293
No	67	596	663
Yes	46	404	450
Grand Total	**152**	**1254**	**1406**
Accommodation Need	**Gender**		
	F	M	Grand Total
N/A	39	254	293
No	74	729	803
Yes	39	271	310
Grand Total	**152**	**1254**	**1406**
Drug Need	**Gender**		
	F	M	Grand Total
N/A	39	254	293
No	97	842	939
Yes	16	158	174
Grand Total	**152**	**1254**	**1406**
Drugs ever misused?	**Gender**		
	F	M	Grand Total
N/A	38	250	288
No	47	291	338
Not Known	14	49	63
Yes	53	664	717
Grand Total	**152**	**1254**	**1406**
Domestic Status	**Gender**		
	F	M	Grand Total
N/A	36	427	463
Married/Partner	13	80	93
Married/Partner/ Domestic Partnership	16	92	108
Not Known	6	68	74
Other	<5	61	N/A
Single/Div/Sep	43	399	442
Single/Div/Sep/ Domestic Partnership	37	127	164
Grand Total	**152**	**1254**	**1406**

Source: Merseyside Probation Trust, caseload 29th February 2012

Appendix 4: Community Prison Offender Passport

The Community Prison Offender Passport is currently used at HMP Liverpool, and aims to address the health needs of offenders and promote continuity of care from prison to community, in line with the recommendations of the Bradley Report (Department of Health, 2009). The passport is currently aimed primarily at addressing the health needs of offenders serving sentences of less than 12 months who do not have support from Merseyside Probation Trust when they are released from prison. As of April 2012, two thirds of offenders who utilise this initiative are serving sentences of less than 12 months.

As part of the passport, information is collected by Community Prison Officers on a range of health needs, from health issues which are more prevalent among prisoners including mental health problems and alcohol and drug issues, as well as other health issues, to wider health needs which have been shown to have a great impact on offender health, and to impact on re-offending (Berman, 2012), including accommodation, employment/training needs, relationship status and financial situation. Community Prison Officers work to address identified health needs, and, when prisoners are released, they have the option of being referred to the Informal Mentoring Project. The project is run by Sefton Community Voluntary Service. The initiative currently covers offenders who are discharged to Liverpool, Sefton and Knowsley, and is being developed for Wirral offenders at the time of publication of this report. Links are also being developed with other prisons, particularly HMP Kennet, which has now merged with HMP Liverpool.

The initiative was implemented in June 2011. Recommendations of this HNA are to review at least a year's data on outcomes including re-offending, for prisoners who have utilised this initiative. This will be available late 2012. Where cost-effective, the initiative should be rolled out to cover all Merseyside prisons. Where possible the passport could also be used for people from other areas who are sent to Merseyside prisons, and people from Merseyside who are sent to prisons outside the area, e.g. women who are sent to HMP Styal. For more information about the project, please contact the Community Prison Manager at HMP Liverpool. An example copy of the Community Prison Offender Passport is attached below.

COMMUNITY PRISON
OFFENDER PASSPORT

CPO Name | **Location** | **Date of Referral**

Please complete this form electronically; all information should be brief, clear, specific and accurate. This will contribute to how offenders are managed before and after release.
No box should be left empty. If there is nothing of note to enter write "None" or "N/A".

If the offender does not engage with the interview or does not want support document this and explain why. The passport MUST still be sent off to the relevant IOM unit even if the offender refuses to be interviewed or engage with support services.

Prisoner Name	Prison No	PNC ID No	Date of Birth

Release Date	HDC Date (If applicable)	Length of Sentence

Address on Release (Inc Postcode)

.

Current Offence Details

Previous Offence Details (if any)

Offender Manager/Supervisor Yes ☐ No ☐

Offender Supervisor Name

Offender Manager Name & Location

Offender Manager Phone Number

Offender Manager E-Mail

1. Accommodation Situation on Release

Support Required

2. Employment, Learning & Skills Overview

Support Required

3. Health & Wellbeing – (Physical, Mental)

Obtain the offenders GP name & address.

Support Required

4. Current Financial Situation

Support Required

5. Relationships & Family Situation

Support Required

6. Alcohol & Drug Issues

Support Required

7. Attitudes, Thinking & Behaviour

Support Required

Have you spoken to the Prisoner about the Informal Mentoring Project and what the service can offer?

Yes ☐ No ☐

Does the Prisoner wish to engage with the Informal Mentoring Project?

Yes ☐ No ☐

If the Prisoner wishes to engage please complete the information sharing agreement and store in the prisoners wing file after being signed by him.

Has the Prisoner had any experience of being in Care?

Yes ☐ No ☐ Prefer not to say ☐

Review Date:

Consider length of sentence when setting review date. This date should be within 28 days of release or before IMP interview, whichever comes first.
Look for release date turning red on spreadsheet.

Review of Targets – Detail progress against targets set or outstanding issues

The following information is to be completed immediately prior to the offender being referred to a partner agency for intervention. This information should be as current as possible.

Wing Conduct Report

Adjudication history during current sentence

Risk Information

The contents of this document are for information purposes only and should not be used for any other purposes.

The prisoner named below is fully aware that the information provided at interview and held on his passport document will be passed to Sefton CVS Informal Mentoring Project or any other agency who may be involved in supporting him on release and he has agreed on a voluntary basis to accept support/mentoring from the Project. The above named person has agreed and understands that there may be a one –to- one review before his release date and that external agencies may wish to speak to him prior to release.

Mentee

Print:	Sign:
Date:	

Completing Officer

Name
Date:

Liverpool Public Health Observatory

Department of Public Health and Policy
Whelan Building
Quadrangle
University of Liverpool
Liverpool L69 3GB

Tel: 0151 794 5570/81
Fax: 0151 794 5588
E-mail: obs@liv.ac.uk
WWW: http://www.liv.ac.uk/PublicHealth/obs

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LIVERPOOL