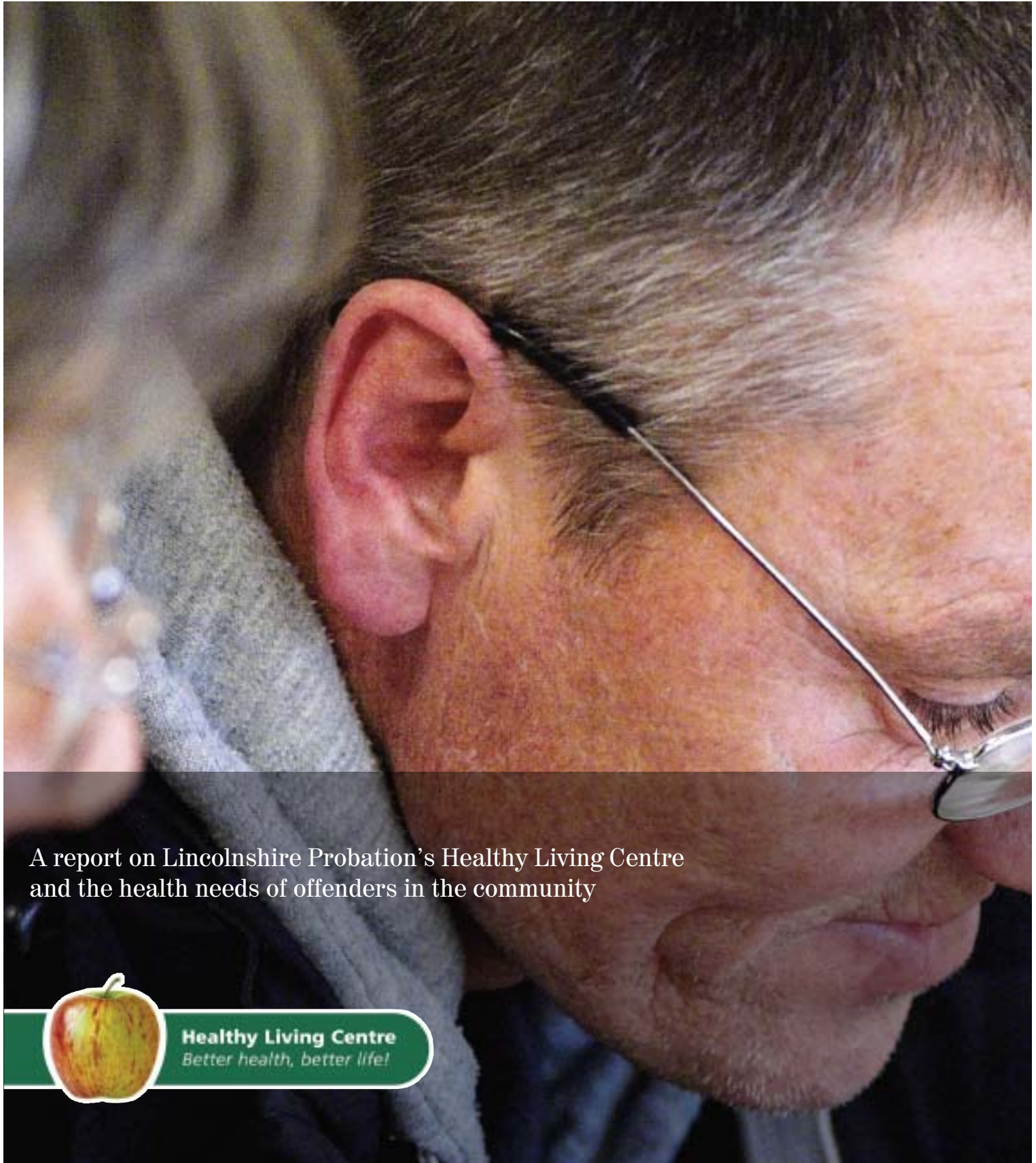


HEALTH OF OFFENDERS IN THE COMMUNITY: THE FORGOTTEN INEQUALITY?



A report on Lincolnshire Probation's Healthy Living Centre
and the health needs of offenders in the community



Healthy Living Centre
Better health, better life!

Acknowledgments

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Abbreviations






A&E	Accident and Emergency
AUDIT	Alcohol Use Disorders Identification Test
CORU	Community Operational Research Unit
DoH	Department of Health
DTTO	Drug Testing and Treatment Order
Hep A/C	Hepatitis A/C
HIIA	Health Inequalities Impact Assessment
HLC	Healthy Living Centre
ICCP	Intensive Care and Control Programme
LIAM/LIAP	Low Intensity Alcohol Modules/Programme
LREC	Local Research Ethics Committee
LtPCT	Lincolnshire teaching Primary Care Trust
NHS	National Health Service
NPS	National Probation Service
NOF	New Opportunities Fund
OASys	Offender Assessment System
OHCS	Offender Health Care Strategies
PCT	Primary Care Trust
PSO	Probation Service Officer
SEU	Social Exclusion Unit
UPW	Unpaid Work

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Executive Summary



Research

The research of the project has been based on an engaged research process in which the researcher has been a partner on the project as part of the Healthy Living team, with continuous debate about the emerging research issues. A number of qualitative and quantitative methods have been employed to ensure that as many stakeholders as possible were included in the research process.

An extensive literature review has revealed the limited research presently specific to the health needs of offenders on community sentences compared to research of offenders in custody. This has implications both for practice and policy if the complexity of offender health profiles in the community are not identified or explored. Whilst gaining access to offenders has not been necessarily easy, the views and experiences that they have shared have therefore been particularly valuable to add to current policy and research debate.

Set Up

As a 'platform of innovation' the Healthy Living Centre (HLC) has developed from concept to organisational reality rooted at local levels of community need. Implementation of the HLC and securing a sustainable future have not been easy processes, given particularly that it was developing a unique service with no other precedents to follow. The HLC has overcome many setup and organisational challenges including changes of personnel in order to provide a dynamic service delivery that best meets the needs of both the offender and the probation service.

Service Model

Over the 5 years of the project a distinctive model of care has been created within the HLC in relation to 'service accessibility' and 'service appropriateness'. Flexibility of provision and approach and the ability to fit the service around individual need has been the cornerstone of service delivery. The 'added value' of the service in terms of time that can be given to a client's appointment and the ability to build up rapport and trust with the nurse were often contrasted with experiences of mainstream health appointments. The

personalising of the health message with an emphasis on listening to what the offender considers are his/her needs in a holistic rather than silo view, was equally seen as central to supporting change.

Role In Probation

The HLC has, over the five years of the project, become integral to the Probation Service in providing a gateway to health services and support for a number of clients who were continually falling through the gaps of mainstream provision and had health concerns that were over-represented in the client group compared with the general population.


The HLC has provided probation case managers with new means to support clients, both by providing them with increased confidence to know how to recognise and respond to certain health issues and new pathways to direct clients. It has also provided case managers with new openings for productive conversations about behaviour and lifestyle choices, with the screening tool a much more informed picture of offender health needs than that presently outlined in the Offender Assessment System (OASys).

As part of a 'multi-modal approach' to enable compliance with the probation order and ultimately reduce re-offending, the HLC was viewed as essential to help break down the complex and inter-related 'vicious circles' that surround most recidivism.

Offender Health Profiles

The study of the HLC has started to unravel the complexity that underlies the wide views and issues behind the statistics of offender health profiles and illustrated a broader approach to the more usual 'definitions' of offender health needs.

The statistics have shown that offenders in the community are approximately three times more likely to be smokers than the general population of England or the East Midlands. High levels of lower-severity mental health problems are reported, and diet is generally reported to be poor. Furthermore, 14% of offenders in Lincolnshire reported that they were not registered with a GP and 65% reported that they were not registered with a dentist.



Offenders reported that health is an 'important value' in their lives, but equally identified structural and individual barriers to change in health behaviour rooted in their sometimes difficult lifestyles, attitudes to risk and health messages, coping, comfort and control strategies. It is against this background that the HLC operates and seeks to effect change in accordance with the particular stage of motivation and ability that the client can achieve. Pathways to change within the HLC are therefore often about taking 'small steps' that fit into the holistic nature of a client's life.

The study has confirmed the vicious circles that exist between poor health, offending and social exclusion for offenders within the community. Moreover it shows that offenders acknowledge that it is within the criminal justice system with initiatives such as the HLC that essential 'gateways' to health access and support are being provided. The challenge for the future is for more partnerships between health and criminal justice systems to identify and break down the inequities that exist in offender health profiles so that help is sought and received within the community before the 'crisis' has occurred.

Introduction

The Healthy Living Centre provides an holistic service that works to improve access to mainstream healthcare services for offenders under probation supervision in Lincolnshire. It is well documented that, in general, the health of offenders is significantly worse than that of the general population; they are less likely to access healthcare services and they experience health inequalities associated with social exclusion and high levels of deprivation. In addition, health has been identified as one of seven major contributors to re-offending. Addressing the problems of health inequalities and re-offending by engaging offenders and building trust in healthcare services is integral to the project's work.

1.1 Report Structure

The report is broken into discussion of the two main areas of the project, the first of which provides an operational point of view and contains brief analysis of some of the quantitative information including prevalence data gathered through basic screening and comprehensive assessment by the nurses, to workshop and gym evaluations, and case progress information. The second part of the report relates to the research context for the work and looks at the mainly qualitative data gathered and analysed by the project's researcher through surveys and interviews. This part also expands on some of the key operational points including the set up and implementation of the HLC and examines academic literature on the broader issues of health inequalities, social exclusion and offender health. Overall, the report brings together a wide range of qualitative and quantitative information which, it is hoped, will inform future community-based offender health projects.

The report is divided into a further 7 sections, with this introductory section giving an overview on the research methodology of the project and present caseload demographics within the National Probation Service (NPS) Lincolnshire. Section 2 explores in detail the background to the project and its service structure, objectives and philosophy. Quantitative data concerning the prevalence of offender health problems is reviewed against the impact of the HLC and its challenges in evaluation. A Health Inequalities Impact Assessment, case studies and follow up data are all discussed to illustrate the wide range of issues

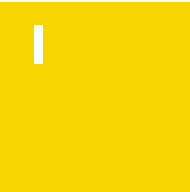
covered within the HLC and the growing understanding of the broad range of offender health needs within the community.

Section 3 begins the research section of the report by placing the HLC within the context of academic debate and policies that have informed both the rationale and need for the setting up of the HLC. Section 4 continues the debate by illustrating how concern about offender health needs identified at a national level were translated into a local solution from project bid to set up. The implementation challenges and successes that surrounded the development of the HLC from concept to a sustainable future are also explored.

Sections 5 to 7 examine the mainly qualitative data of the research in relation to the innovative characteristics of the service model and the role that the HLC has developed within the probation service. Section 7 discusses the views of offenders not only in relationship to the HLC, but what underpins their health profiles and behaviour and the pathways between health, offending and the criminal justice system. The final section reflects on the operational and research issues raised within the 5 years of HLC and what can be recommended for future partnerships between health and criminal justice systems.

1.2 Research Methodology

The researcher's role within the HLC has been one of 'engaged' research in which the emphasis has been on the researcher being a partner on the project, a part of the process not just an external evaluator. Indeed, the role of the Community Operational Research Unit (CORU) within the project began with its facilitation of the offender survey for the bid in 2001. The researcher has been a member of the HLC steering group from its inception, and considered part of the Healthy Living team, with attendance for example of monthly Healthy Living meetings and other meetings/activities considered applicable. The research process has therefore not just been one of gathering snapshot data and views in a vacuum, but one of evolving engaged research with fluid and continuous debate between Researcher and 'researched' about the dynamics of the project and its emerging research issues.



One of the main roles of the research throughout the project has remained the placing of the project in its national context of health inequalities and developments in the criminal justice system through extensive literature reviews and current academic and policy debate. The objective being that the widest 'lessons' could be learnt from the HLC, not a project to be viewed in isolation. Criticisms have been made within Hills et al (Bridge Consortium) final evaluation of HLCs ... *'that they have not always been undertaken with the aim of generating 'knowledge' or generalisable 'evidence' of effectiveness'* (2007;p40). Whilst acknowledging the challenge this brought, the onus was on always how to take the individual case study of the HLC and transfer principles into wider practice. There was equally an existing research gap/vacuum concerning the health needs and behaviour of offenders in the community to which the research could contribute much more understanding both in terms of health structures and offender health needs and attitudes.

The main aims of the research undertaken by CORU in partnership with the Healthy Living team were consequently:

- To identify and analyse the 'holistic' health needs of offenders within the community;
- To explore and evaluate the project/partnership's 'impact' and understand the means of engaging offenders and assessing/addressing their health needs;
- To contribute further 'knowledge' of the nature of inequalities in health and health promotion;
- To identify the barriers/enablers for healthier lifestyles and their consequent implications for the wider community;
- To understand if the programme initiates a process of change that may impact on the participants' engagement and compliance with the probation service and whether there are joint pathways between health and re-offending?

1.2.1 Data Collection

During the research a number of qualitative and quantitative methods were employed to ensure that as many stakeholders as possible were included in the research process. These included:

- Semi-structured interviews with the Healthy Living team, probation staff and offenders;
- Focus groups with offenders;
- An offender survey;
- Follow up surveys;
- Observation and participation as part of being a team member;
- Review of project documentation.

1.2.2 Ethics

The research was subject to the ethical approval of the University of Lincoln within the Faculty of Business and Law and the Lincolnshire Local Research Ethics Committee (LREC). All participation within the research was voluntary and confidential and based on informed consent with the application of the appropriate information sheet and consent form. The interview schedule, surveys, consent forms and information sheets all required the prior approval of the LREC and were subject to continual monitoring, reporting and ethics audit.

1.2.3 Interviews and Focus Groups

A total of 47 semi-structured interviews were conducted by the Researcher and are detailed in Sections 5, 6 and 7. These involved interviews with 8 members of the project team past and present, 12 case and programme managers most involved with the project including the Lincolnshire Approved Premises and 27 offenders. Two focus groups with 9 offenders were further undertaken. All interviews and focus groups though based on approved questionnaires were semi-structured and explored the research aims identified in the research proposal. Interviews were recorded as extensive interview



notes and then analysed to provide a framework of emerging themes.

Interviews with offenders were based on convenience sampling with their being invited to participate either through the Healthy Living nurses or case manager. Given the erratic attendance of the client group there were many occasions where clients failed to turn up: out of a recorded 10 visits to the Lincoln probation office for interview sessions, for example, only 5 interviews out of a possible 33 took place. Despite these difficulties through the valuable support of the HLC and the willingness of offenders to participate, very valuable insights on health needs and attitudes were gained from a range of clients. It had to be recognised however that the sample would not be 'representative' in any strict research constraint and that both in this and in surveys 'convenience sampling' was the practical compromise.

1.2.4 Offender Health Survey

Clients were invited to participate in the Offender Health Survey whilst attending probation appointments mainly at the Lincoln office, due to the larger volume of clients than at other offices. Mainly the Researcher administered the survey with support from the Healthy Living team and it required many visits to obtain a reasonable response rate of 100 clients. On average 4 or 5 clients were willing to complete a survey per afternoon or morning session at the Lincoln office. The Healthy Living Probation Service Officer (PSO) also undertook surveys in smaller offices to ensure that a geographical spread of responses was obtained. The survey contained a mixture of tick box and open responses, which elicited an interesting range of qualitative and quantitative data on health profiles and experiences, attitudes to health services, probation and the criminal justice system. All respondents who participated in interviews, surveys and focus group were generous with their time and opinions and many offenders were open on what were very often sensitive issues.

Overall, the report brings together a wide range of qualitative and quantitative information which, it is hoped, will inform future community-based offender health projects.

Except where stated, all figures relate to the first five years of the project's work (up to 31st January 2008). Where percentages of offenders are shown for screening and assessment data, they relate to the proportion of offenders out of the total number screened/assessed, including those who declined to answer the question.

1.3 Caseload demographics

There are, on average, slightly over 2000 cases being managed the NPS Lincolnshire at any one time. The tables and figure below provide a snapshot of how the Lincolnshire probation caseload (as of 6th March 2008) can be described in terms of race and ethnicity, age and gender. In addition, at least 7% of the caseload is known to have a disability (as defined by the Disability Discrimination Act).

Table 1: Caseload by race and ethnic category

Race and Ethnic Category	Percentage
Asian or Asian British: Indian - A1	0.19%
Asian or Asian British: Pakistani - A2	0.05%
Asian or Asian British: Bangladeshi - A3	0.09%
Asian or Asian British: Other - A9	0.14%
Black or Black British: Caribbean - B1	0.43%
Black or Black British: African - B2	0.43%
Black or Black British: Other - B9	0.28%
Mixed: White & Black Caribbean - M1	0.47%
Mixed: White & Black African - M2	0.24%
Mixed: White & Asian - M3	0.05%
Mixed: Other - M9	0.09%
Chinese - O1	0.19%
Other Ethnic Group - O9	0.57%
White: British - W1	90.09%
White: Irish - W2	0.71%
White: Other - W9	5.60%
Not Stated/Refused - NS	0.38%
Grand Total	100.00%



Figure 1: Caseload by age band

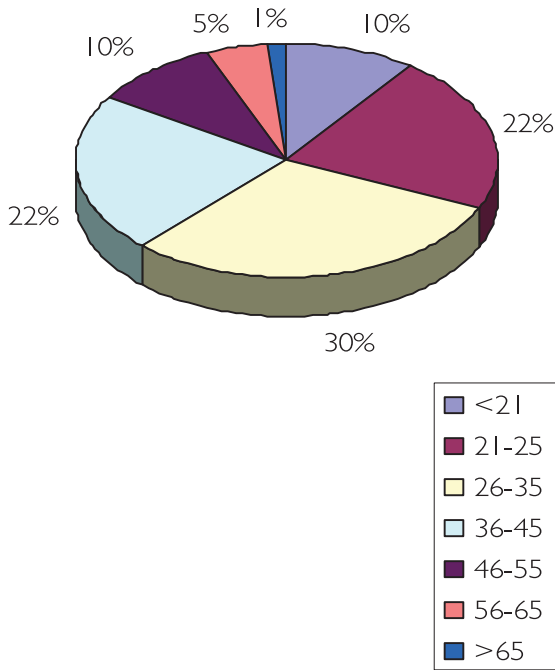


Table 2: Caseload by gender

Male/Female		Total
Male	Number	1892
	Percentage	89.7%
Female	Number	217
	Percentage	10.3%
Total Number		2109
Total Percentage		100.0%

Discussions on health inequalities often concentrate on geographical areas of need, as demonstrated by the identification of Spearhead areas – those Local Authority areas with the highest quintile of deprivation in the country. There is also recognition that health inequalities exist for particular socially excluded groups, for example offenders in custody or in the community and asylum seekers. However, there is often a direct link between geographical areas of deprivation and some of the groups that also experience health inequalities. Therefore in targeting socially excluded groups in a non-geographical manner, resources are also being targeted towards these geographical areas while not excluding those with similar needs who live outside them.

Operational review and quantitative evidence

2.1 Background

Lincolnshire is a large and rural county – the probation area is one of the largest in England and Wales yet has one of the smaller caseloads. This brings particular challenges to service delivery, especially where the services are being delivered for small numbers of offenders from many offices around the county. In addition, there are two areas with particularly high levels of deprivation within the county – Lincoln City and the East coast.

While the health of prisoners had been examined in several studies, with conclusions that prisoners' health was, in general, far worse than that of the general population, there was little, if any research into the health of offenders in the community. Around two-thirds of offenders are given community sentences and do not go to custody, so the majority of those who go through the courts were being missed in this research. In addition, those offenders in custody are released and still have to deal with the identified health issues in the community. These health problems may not be addressed in the community due to wider concerns including social exclusion, deprivation, homelessness, poor educational background and mistrust of mainstream services. This is examined in more detail in Section 3.2.

With health being identified as a problem for many offenders managed by the NPS Lincolnshire, a bid was made for funding from the Big Lottery Fund (then the New Opportunities Fund) in 2001 as the Healthy Living Centres Programme was introduced. The initial submission was successful and resulted in an invitation to submit a second stage bid, for which a snapshot survey was carried out in partnership with the University of Lincoln. This was also successful and the project was awarded £1,000,000 funding in 2002. Work began in February 2003, initially for a period of 5 years but later extended by 6 months to 31st July 2008. Over this time, health has become firmly embedded in the work of the Lincolnshire Probation Area and the importance of addressing offender health has been given increasing importance. The partnership with the University of Lincoln also continued, allowing the project's practical work to be backed by ongoing anonymised data collection and research into the health needs of offenders in the

community in Lincolnshire and their access to healthcare services.

2.2 Service Structure

The three broad project aims are to:

- Improve access to mainstream healthcare services for offenders under probation supervision in Lincolnshire;
- Improve offenders' knowledge of health promotion issues so they can make healthier lifestyle choices;
- Research the health and healthcare needs of offenders under probation supervision in Lincolnshire.

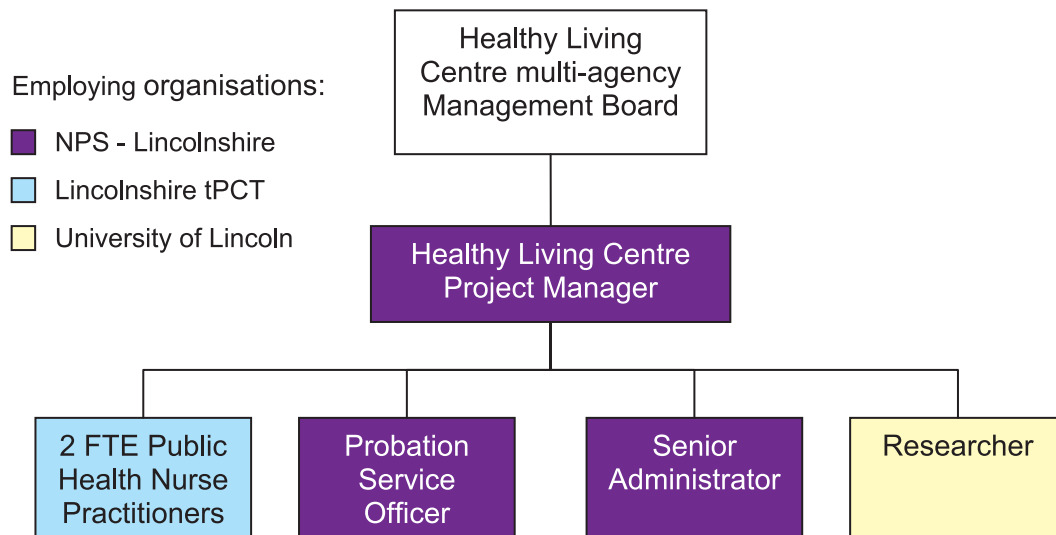
The achievement of these aims should, in turn, have a positive impact on the broader issues of health inequalities and re-offending and on the evidence base on which future policies and services can be built.

The Healthy Living Centre is staffed by a multi-agency, multi-disciplinary team managed by the NPS Lincolnshire. It is overseen by a management board that represents all key organisational stakeholders and is shown in Figure 2 below:

The project works with Offender Managers within probation to screen the health of all those commencing a community order or who are released into Lincolnshire on licence from prison. The screening tool was developed for the project as a quick and simple way of obtaining an indication of the state of an offender's health, well-being and lifestyle. Primarily, it enables the Offender Managers to engage the individual in a discussion around health and offer the opportunity for further intervention by the Healthy Living team if appropriate.

Public Health Nurse Practitioners seconded from Lincolnshire teaching Primary Care Trust (LtPCT) offer comprehensive health assessments and use these hour-long appointments to offer individualised advice and a signposting and referral service. The assessment covers all the main areas of health, both

Figure 2: Healthy Living Centre staff structure



physical and mental. It is often used as a method of opening broader discussion and identifying underlying problems that may be different to what an offender originally presented with. The assessment question answers are stored anonymously, adding to the wealth of data that the project has been able to collect.

In addition to screening and assessment, the Project funds a Probation Service Officer who co-ordinates and runs various health promotion workshops for offenders. These are brief interventions usually lasting 1-2 hours and are run in a wide range of health and well-being topics including smoking cessation, alcohol awareness, sexual health, men's health, women's health, dealing with stress/anxiety, self esteem and relaxation. The workshops are often delivered in conjunction with the nurses and with other agencies such as the Lincoln City Activity Initiative who carry out health checks such as blood pressure, Body Mass Index, grip strength etc.

By taking innovative approaches to service delivery the project has worked to engage this notoriously hard-to-reach group, many of whom have a history of not accessing mainstream healthcare or have become withdrawn from mainstream services due to a stay in prison, substance misuse problems or bad experiences with healthcare. The location of Healthy Living appointments plays a key role, as found when attendance rates improved after the service moved

into local probation offices instead of health centres, demonstrating that offenders are more likely to use the service if it is co-located with probation. Offering appointment times of an hour for assessments ensures that there is time for the offender to build trust in the nurse and for concerns to be discussed without feeling under pressure. This has been identified by offenders as an important aspect of the service that has enabled them to engage and tackle problems that have previously remained unaddressed (see section 7.1.1 for further details). In particularly complex cases, the nurses will also schedule repeat appointments so that progress and referrals can be managed at a pace that is comfortable for the individual.

The offender pathway through Healthy Living services is shown in Figure 3 below (figures shown relate to Year 5 – 1st February 2007 to 31st January 2008):

2.3 Evidence of need

Several sources of data from the project demonstrate the continued level of need among offenders in the community. It highlights an extremely high prevalence of smoking among offenders in Lincolnshire (75% of offenders screened over the first five years of the project reported smoking; full screening data is shown below). This would be expected given the higher prevalence of smoking among: routine and manual

Figure 3: Offender pathway through Healthy Living services

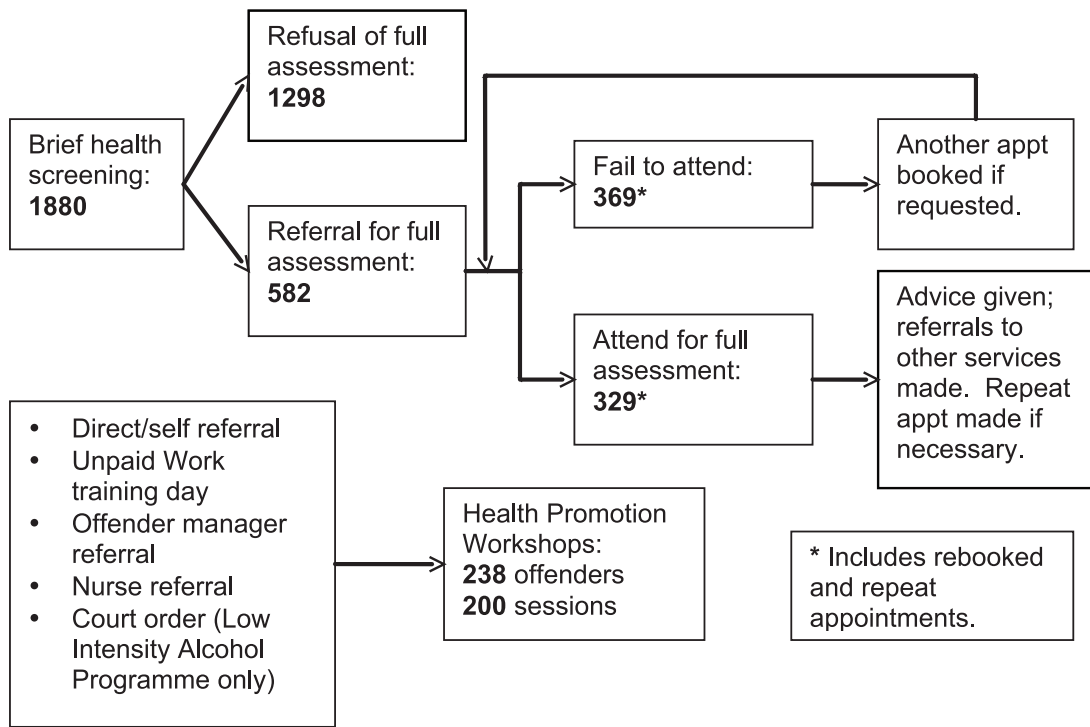


Figure 4: Smoking prevalence over time for different groups

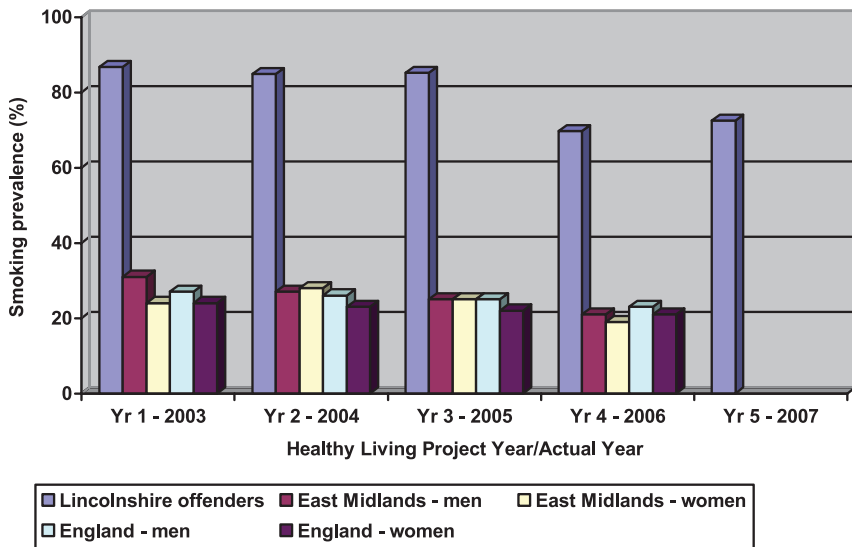
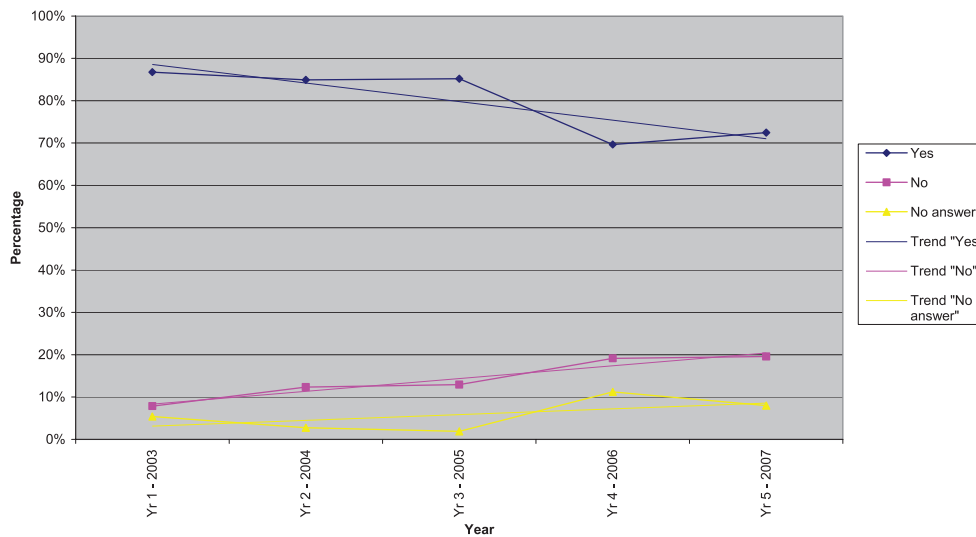


Figure 5: Proportion of answers to screening questions, "Do you smoke?"



workers (compared with non-manual); the unemployed (compared with the employed); and renters (compared with home owners). Figure 4 demonstrates the enormous difference in smoking prevalence between Lincolnshire offenders and the East Midlands/England as a whole.

Figure 5 also demonstrates the trend in smoking. The apparent drop in prevalence is most likely due to a combination of factors including social marketing, a drop in the level of social acceptance and the introduction of specialist NHS smoking cessation services, with the Healthy Living Centre also playing a role in delivering health promotion messages.

Screening and assessment data up to the end of Year 5 also suggests:

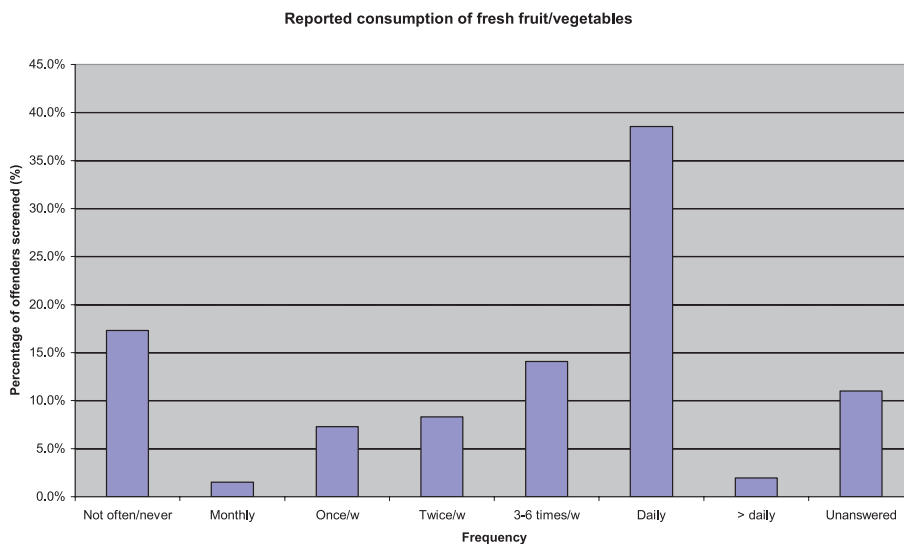
- There is a high prevalence of sleep problems – 37.2% of the offenders screened over the first five years of the project report not sleeping well compared with 24% of men and 34% of women reporting sleep problems in the 2000 psychiatric morbidity survey;
- There is a high prevalence of lower-severity mental health problems, such as anxiety, stress and/or depression - 44% of those screened reported such problems at the time of screening

in the project's fifth year and 52.3% of those assessed reported having suffered mental health problems in the past;

- There is a high prevalence of self-harm and suicide – 16.5% of all those assessed reported having attempted suicide; 27.3% of all those assessed reported having deliberately harmed themselves;
- The offenders screened have a smaller intake of fresh fruit and vegetables – 48.5% report not eating fresh fruit or vegetables at least once per day (see Figure 6 below for screening data);
- 14.1% of offenders screened over the course of the project's initial five years reported they were not registered with a GP and a further 6.2% declined to answer or were unsure;
- 64.7% were not registered with a dentist; and
- 13.8% did not eat a meal every day.

A survey of the health and health needs of Lincolnshire offenders showed that only 38% of respondents reported eating fresh fruit/vegetables daily, while 11% reported eating fast food daily, demonstrating that more needs to be done to

Figure 6: Reported consumption of fresh fruit/vegetables by offenders



encourage the 5-a-day message with this group. Further details on and results from the offender survey can be found in Section 7.

2.4 Impact of service

2.4.1 Evaluation Challenges

The Bridge Consortium, commissioned to evaluate the Big Lottery's Healthy Living Centres, stated in its third annual report:

'As HLCs move towards the end of their lottery funding, there is a growing sense of pressure that they need to be able to demonstrate that they are having an impact on the health and wellbeing of their local populations. This presents a considerable challenge, given their broad aims and the wide range of different activities that they are providing.'

Lincolnshire Probation's Healthy Living Centre is no different to any other in this respect. Due to the holistic nature of the project's services and its aim to refer offenders into mainstream healthcare provision, the final effect of the service on an individual is difficult to evidence. Timescales also add to the difficulties in showing that the project is impacting on high priority areas such as coronary heart disease, high blood pressure, strokes, cancer, et cetera, as the

project's intervention is very short and the final impact of the lifestyle changes it promotes could only be seen in the long-term and proven with longitudinal studies. However, as the Bridge Consortium's final report acknowledges, "Producing evidence of interim outcomes is a valid aim when evaluating community based interventions" and as guidance from the Department of Health and Neighbourhood Renewal Unit states:

'Sometimes, however, it is not possible to measure a health outcome directly. Death rates from heart disease are a poor measure of the success of a local strategy to encourage people to take exercise... However, it is known that lack of exercise is linked to a higher risk of heart disease. It is sufficient therefore at a local level, to know that more people are putting themselves into a lower risk category by taking exercise, and how often.'

2.4.2 Workshops and gym evaluation

Analysis of the responses to workshop evaluations demonstrates that offenders have a better understanding of a range of health-related topics as a result of the health promotion sessions, as illustrated by an average change from 2.9 to 4.4 in the self-rating of knowledge on the subject before and after the workshops (on an integer scale from '1 – none' to '5

– very good'). Similarly, follow-up surveys show they have an increased awareness of their own health and how to improve it and many have taken action due to the individualised advice given by the nurses. Service users have also reported having a better idea of where to go to access the appropriate service and many have reported that their health problems are now being addressed by their GP after the nurse wrote a letter summarising the significant findings of the health assessment.

Evaluations of gym memberships, completed by those offenders for whom the project has funded three-month temporary memberships to assist with increasing exercise where there is an identified clinical need, have shown a significant self-reported improvement in level of fitness from an average of 2.1 to 3.7 on a scale of '1 – not very fit' to '5 – very fit'. In addition, 92% have said that they will continue to go to the gym or do other exercise at the end of the 3-month period. Approximately 10% of those for whom local gym membership was funded have successfully attended at least three times per month for the three-months, as is expected and agreed upon referral. However, for those who are successful with the Healthy Living Centre's membership funding the feedback is extremely positive. An example of this is described in Case Study 1 (see Section 2.5).

Both gym and workshop evaluations ask offenders how useful they think it is to have a Healthy Living Centre within probation. On a scale of '1 – not useful' to '5 – very useful', the mean score is 4.3 on workshop evaluations and 4.8 on gym evaluations.

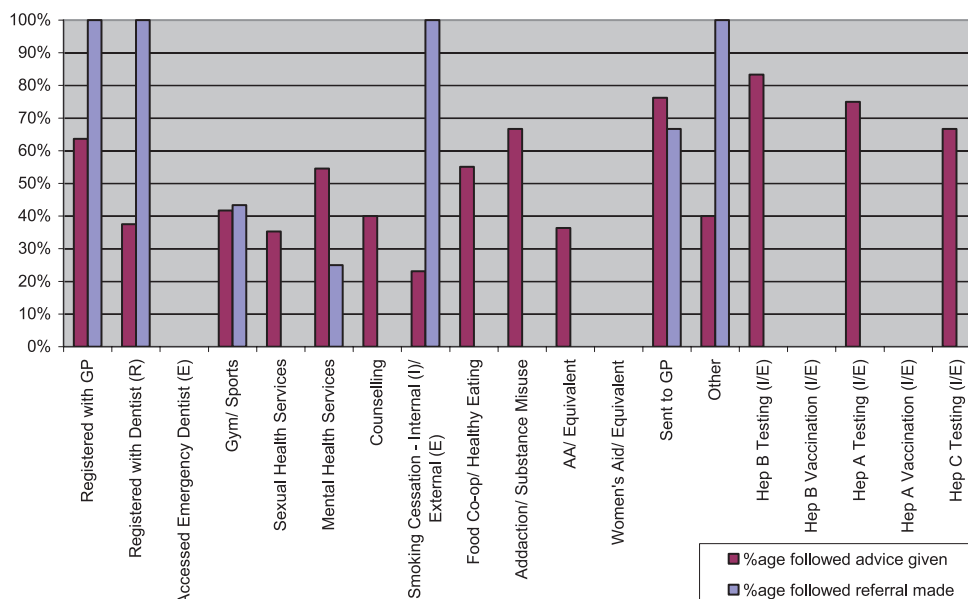
2.4.3 Resource for Offender Managers

As evidenced in the project research, probation Offender Management staff realise the benefits and take full advantage of having knowledgeable and experienced health staff available to give advice. They are now better equipped to help their offenders address health problems and are more aware of how health can impact on other areas of the offenders' lives. They are also able to spend more time concentrating on other areas of need relating to offending behaviour; in the knowledge that the Healthy Living team are available to address the health needs.

2.4.4 Health Inequalities Impact Assessment

In the process of working to achieve mainstream continued funding for the project, a Health Inequalities Impact Assessment (see Appendix) was carried out in an attempt to evaluate the importance and scale of the impact on project funding ceasing. It took the

Figure 7: Percentage of offenders following nurses' advice/referrals

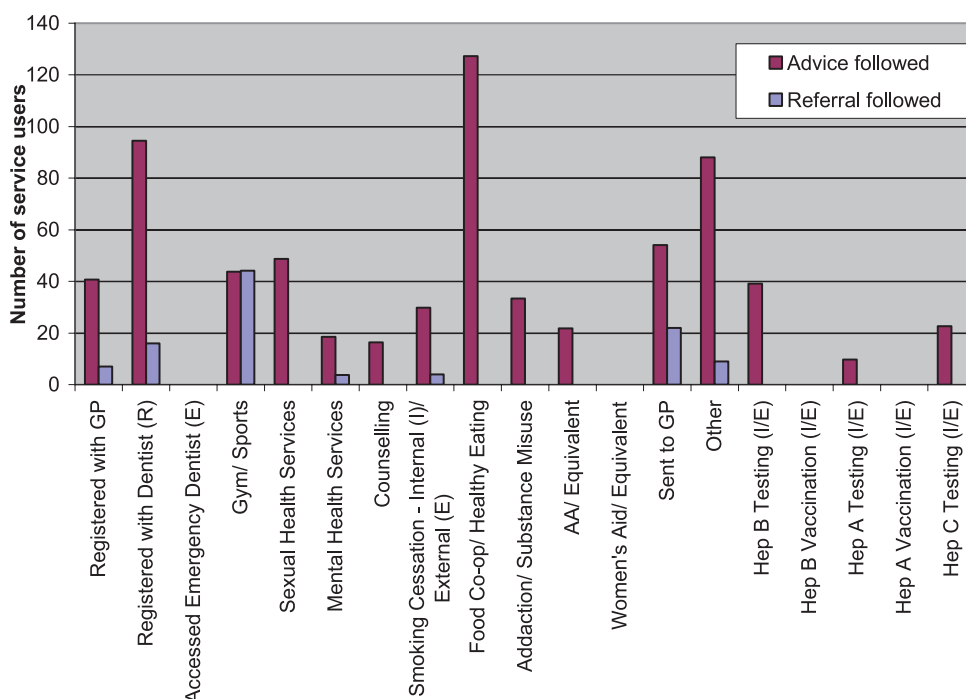


form of a meeting which was conducted with a range of stakeholders including service users, Probation Service Officers, the Healthy Living staff team and members of LtPCT and led by the Assistant Director of Public Health and Partnerships. Impacts were rated according to their perceived likelihood and relative importance across a range of health determinants and affected populations. The results showed negative impacts across the whole range and particularly on the personal/family circumstances and lifestyle of both the service users and their families and carers. Negative impacts were also shown across a range of public services including reduced access to primary health care and a potential increase in inappropriate presentations at Accident and Emergency services. The HIA has shown that the effects of the HLC have reached far beyond the individuals who use the service. Other studies have highlighted that there are significant potential cost savings to the NHS from improved health knowledge and healthier lifestyles, earlier intervention for health problems and more appropriate use of services. Similarly, there are significant cost savings for the criminal justice system in reducing re-offending and gains for the economy as a whole through helping more people maintain or enter employment.

2.4.5 Alcohol awareness and misuse services

The Healthy Living Centre is involved in the Lincolnshire area pilot of the new Low Intensity Alcohol Programme (LIAP) (formerly called the Low Intensity Alcohol Modules, or LIAM) which is targeted at offenders who are not alcohol dependent but for whom alcohol has contributed to offending behaviour and who have a low to medium risk of reconviction. The initial results of its national evaluation show that it has had a positive effect on alcohol knowledge and scores on the Alcohol Use Disorders Identification Test (AUDIT). Areas of the programme, particularly on units and the health effects of alcohol, were used to create a shorter Alcohol Awareness workshop for offenders which gives key facts and messages about alcohol in just a couple of hours. In addition, a day-long alcohol awareness workshop, developed by Leicestershire Probation Area, is delivered to offenders with Unpaid Work (UPW) orders who have an identified problem with alcohol or who are interested in learning more. These interventions filled what was a large gap in mainstream alcohol misuse service provision, however mainstream services are now being expanded or introduced using a significant amount of funding from Lincolnshire tPCT.

Figure 8: Estimated numbers of service users following direct advice/referral from a Healthy Living nurse



2.4.6 Follow-up data

Information from case progress sheets show whether advice has been given and/or referrals made and whether they have been followed for a wide variety of topics. They are completed at the initial appointment with a nurse and updated if they return for a subsequent appointment; however it proved extremely difficult to systematically follow up all service users. Practical systems by which to start doing this were put in place during Year 5 and the vast majority of these follow-ups are completed over the phone by a member of the team who is not the nurse the offender saw. The main reason for this is to try to improve the reliability and truthfulness of the answers, and to reduce the likelihood that the offender will give the answer the nurse wants to hear so as not to disappoint. In addition, the case progress updates are done alongside follow-up surveys asking the offender what they liked/disliked about the project and their experience of Healthy Living and they are more likely to be open about any problems or bad points if they do not have to complain to the potential subject of their complaint.

Of all the 1616 case progress sheets completed to date (including those completed in Year 6), 430 (27%) of these are from the project's fifth year onwards (from February 2007). Of these, 80 (19%) are known to have been followed up. When comparing those that have been followed up with those that have not, a significant difference in the proportion of people who are known to have followed the advice/referrals is highlighted. It will never be possible to follow up every offender due to changes in contact details, recalls to prison, unavailability due to employment, etc. We therefore need to assume that the service users with whom we were able to make contact are representative of Healthy Living service users as a whole, and for that reason the proportion following advice could be extrapolated from this group to all those service users.

For example, since February 2007, 64 offenders have been given advice on registering with a GP but only 11 (17%) were known to have followed that advice. However, of the sample followed up, 64% have reported that they followed the advice given. Using that as a basis, it can be assumed that approximately

41 service users have registered with a GP on the advice of the Healthy Living nurses since February 2007. Figures 7 and 8 show two graphical summaries of the full case progress data from February 2007 onwards.

2.5 Case studies

The project has collated numerous case studies and reports of offenders who have benefited in life-changing ways from the assistance of the Healthy Living team, from those who have regained their trust in GPs and accessed appropriate treatment for the first time in years, to those who have been motivated to reduce their alcohol consumption to safe levels and now report feeling more in control of their lives and ready to go back into education, training or employment. For many, this progress has not only reduced their risk of re-offending but has also had a positive effect on their friends and families and will reduce the burden on other health services in the future. Detailed below are just five of these case studies.

Case study 1 – "John"

John first attended Healthy Living having recently been released from prison. At the time his case manager stated that he was not engaging well and they found him difficult to work with due to his attitude.

During his appointment with the nurse he displayed anxiety and stated that he had issues around social anxiety and panic attacks, that he was very nervous about company and did not integrate well. However, he engaged in the session and although he was "edgy" he was communicative.

John stated that he had some weights at home and regularly undertook exercise but would prefer to build his confidence by attending a gym. The nurse informed him that the Healthy Living Centre did not currently have an agreement with a gym in his home area and he stated that he would be willing to see if his local gym would consider entering into such an agreement. This, in itself was a positive step for him to volunteer to undertake.

The nurse spoke with John a few days later and found that the gym was prepared to enter an agreement. She visited the gym to verify its suitability and found it to be a very supportive environment, so a referral was made.

John voluntarily informed the owner of his offence and what had occurred and the owner supported John. Gradually, his confidence grew and he integrated excellently.

His attendance at the gym has been excellent (virtually daily) which has had the benefit of integration, socialising within a pro-social group, anxiety alleviation as his confidence has grown, as well as the positive physical benefits of exercise. He has remained drug free and been included in other gym events.

Following discussion with the gym owner who confirmed John's commitment, progress and integration, and discussion with John's case manager who confirmed his compliance and positive attitude change, it was decided to continue his membership for an extra 3 months because of the positive effect on him and the strong indication of lifestyle changes that could definitely contribute to:

- Enhancement of his emotional well-being and stability and
- Reducing the risk of him re-offending.

John recognised the impact his decision to change was having on his life and became highly motivated to maintain the positive moves he made:

"The likelihood of me re-offending if I hadn't had the gym to focus on was massive but now I'm looking for work, going to the gym most days and have met a different type of people who aren't involved in drugs or crime. Thank you for this."

Case study 2 – "Brian"

Brian's recent offences were committed under the influence of alcohol. He is a 38 year old man who has a history of self harming, split personality disorder and depression. He's a former alcohol

abuser who was assessed by a Healthy Living nurse a couple of weeks after attending an alcohol workshop run by the project Probation Service Officer. He reported to the nurse that he had been shocked to realise the truth about his drinking - he drank 20 pints a day on average. Since then he has cut down dramatically and now has only two pints a week. This was confirmed by his case manager who had said he was much easier to deal with after cutting down. Brian did say that his girlfriend had given him an ultimatum, but by his own admission it was the workshop that acted as the catalyst in triggering his behaviour change. He also reported copying the alcohol tables given to him at the workshop and giving copies to his drinking mates and the pub landlord.

Brian's case provides a real demonstration of how the impact of the Healthy Living Centre has the potential to reach beyond the offenders with whom staff members have contact. The project's brief interventions through health promotion workshops are designed to provide the facts about different areas of health and well-being and to motivate attendees to make healthy lifestyle choices. The option of referral to the nurses is made clear so that further advice, support and referrals can be offered if appropriate.

Case study 3 – "Kate"

Kate was referred for Healthy Living-funded gym membership by the nurse as she was overweight and reported suffering from depression and stress. She successfully completed the 3 month membership period (i.e. attended at least 3 times per week every week) and this, in conjunction with the nurse's advice on diet and healthy eating, helped her lose a stone in weight over the 3 month period. Recent problems and stressful situations contributed to her putting some of that weight back on, but she stated to the nurse, "If it hadn't been for the gym I'd have definitely been back to the doctors for some anti-depressants by now". She also reported that going to the gym had increased her self-confidence because she now felt better about herself. Kate's membership was extended for a further 3 months to reward her commitment and allow her the opportunity to build on the excellent progress she had made.

Kate provides an example of how the holistic nature of the project can benefit those with physical or mental health issues, or a combination of the two. The benefits of exercise are wide-ranging and as well as being important in weight management and general physical fitness, exercise can assist in easing stress, can provide a new focus for those recovering from drug or alcohol addiction and can open up new social networks.

Case study 4 – “David”

David is an alcoholic who had lost his managerial job and his family through drinking and he found himself under probation supervision. He had already linked with an alcohol specialist practitioner and appeared motivated to change. His Offender Manager liaised with the nurse prior to the initial appointment as there were concerns regarding his health and eating. This enabled the nurse to gather information on the effects of alcohol on the body and more specifically, how excess alcohol affects protein metabolism and the absorption of vitamins and minerals, leading to malnutrition. At his assessment, David explained to the nurse how he would often go days without eating and no longer felt hungry at all. The biological reasons for this were discussed and realistic targets were agreed. These included starting with nutritionally balanced drinks and moving on to small amounts of more solid food if possible, even if he did not feel hungry. David was given a food diary so he could measure his progress and, at his follow-up appointment, positive reinforcement of his consistent improvement and commitment was given. New targets, such as trying Weetabix or 2/3 tablespoons of beans and a slice of toast, were set and David was encouraged to liaise with his GP regarding a “well man” check-up. David was due to attend a final follow-up 8 weeks later but was unable to attend due to gaining full time employment – a new appointment outside of his working hours was therefore arranged. He reported to his case manager a large improvement in self-esteem; his alcohol consumption reduced significantly; his risk of self-harm reduced and he continued to make slow but definite progress with his eating. David’s motivation to change was reinforced by excellent collaborative working between Healthy Living, his

Offender Manager and his employment guidance officer, leading to a noticeable positive change in his lifestyle.

David’s case is an example of the wide range of issues that have been encountered by the Healthy Living nurses over the course of the project. The information and advice offered to offenders is tailored to their health needs and their level of understanding. David was able to comprehend some of the more complex details regarding his problems and that background understanding helped him to make progress. However, for others it is more appropriate to keep the background information simple and concentrate on practical advice and direction.

The project has produced its own literature around certain areas that were identified as being common concerns and for which there was little or no suitable material, including “Food First Aid” – a leaflet on how food and drink can affect mood, and a “Guide to Getting Fit for people on probation in Lincolnshire” – a booklet which provides information on basic exercises and ways of keeping fit at little or no cost, as well as information on the benefits of physical activity and other places that can offer support.

Case study 5 – “Paul”

Paul is Latvian and did not speak much English so was seen in the presence of an interpreter. He had significant issues including constant anxiety, being unable to sleep and various long-term physical health problems that remained unresolved. He had been unable to communicate these problems to mainstream services due to language barriers and they were causing him distress, as well as potential further medical complications. The Healthy Living nurse drafted a letter to Peter’s GP stating all the facts that had been ascertained from his full health assessment. Peter was provided with two copies in sealed envelopes – one copy to take to his GP and another copy for the interpreter to read to him and for him to keep, so that he knew exactly what the letter stated. The nurse also notified the GP that Peter would be attending. Peter attended his appointment with the GP and the interpreter fed back to Healthy Living that he had found it a very positive experience. Peter also specifically asked his

Offender Manager to tell the nurse that the GP had tackled all the issues raised, provided suitable medication and management and that he was now much happier.

The Healthy Living nurses will offer an appointment and equitable service to any offender who wishes to be referred. This sometimes results in appointments being carried out through an interpreter; and a longer appointment time is offered wherever possible to facilitate this. As in Paul's case, the nurses frequently facilitate GP registration and/or provide written health needs summaries in order to help the GP better address the offender's health concerns. This saves time for the GP and allows them to be better prepared when the patient arrives for their appointment, while giving the offender greater confidence that they will be able to communicate their problems without feeling rushed.

2.6 Operational conclusions

The Healthy Living Centre has been successful in bringing the health and criminal justice services together to deliver a programme that offers benefits to all stakeholders.

The impact on its service users has been mixed and depends on their level of motivation to change. For some, the intervention of the project has had such a profound effect that they believe they would not be alive without it. For others, it has been an activity completed to try and please their offender manager with which they have not engaged beyond completing paperwork. However, for the majority it has given them an opportunity to learn about their health, how they can prevent further deterioration and improve it; it was a chance to discuss concerns in a relaxed and unhurried environment and it has provided a gateway to access the appropriate healthcare that can assist them with their problem. Moreover, it has been an opportunity to take away advice on how they can live a healthier life and change one or two things that may reduce their risks of further health problems in the future. In so doing, they will also be addressing one of the pathways out of re-offending.

Research – literature review

3.1 Background to the Healthy Living Centres

Researching the issues of the HLC meant understanding the complex layers that surround its operation and meaning in terms of health inequalities, offending and the criminal justice system. A review of literature pertaining to the Healthy Living Centre was hence a paradoxical situation in that whilst literature concerning the issues of the HLC as health inequalities, health promotion and offending is vast, there is very little specific to the health needs of offenders on community sentences compared to research of those in prison. A comprehensive review by the Offender Health Care Strategies (2005:p1) for instance found *'that there was little evidence of research into health services for offenders outside of custody.'* The literature review therefore considers the wider academic and policy landscape in which the HLC came into operation and the gaps in the literature that the research sought to provide some insight into.

Addressing health inequalities as acknowledged in the final evaluation of the Healthy Living programme by Hills et al (2007) is not an easy issue either in understanding its causes or its redress. The Black Report of 1980 being one of the most significant documents for opening up the debate on trends and causes of health inequalities and for its emphasis on the social model of health recognizing that many of the problems of health inequalities lay outside of the scope of the NHS being related to social and economic factors. It also considered the interaction between what was perceived as the two fundamental causes of health inequalities. That is the materialist/structural explanation with its emphasis on the role of economic, social and structural causes such as income, employment, education and housing and the relationship between the cultural/behavioural explanation which perceives inequalities as rooted in 'certain styles of living', such as smoking, lack of exercise and poor diet.

The Black Report was also important for highlighting evidence of inequality of access to services as Hart's (1971) Inverse Care Law in that the least advantaged social groups often have poorer access to health services with those groups in greatest need making the least and often inappropriate use of services. Indeed 'service accessibility' and 'appropriateness' were

two of the 7 clusters of explanations given for causes of health inequalities in Hills et al (Bridge Consortium 2007) final evaluation of the HLC programme.

Whilst the Black Report brought health inequalities to the fore and advocated a holistic view of health not just a service-orientated approach, it was not until the late 1990s with the publication particularly of the Acheson Report (1998) that the focus was shifted away from an emphasis on individual health behaviour to supporting change that was beyond the 'control of the individual'. Such policy change was advocated against the 'failure' of conventional health promotion to address the widening gaps in health outcomes and an increasing importance given to partnership *'to attack the breeding ground of poor health – poverty and social exclusion in creating strong local partnerships with local authorities, health authorities and other agencies to tackle the root causes of ill health'* (Saving Lives – Our Healthier Nation, 1999).

It was against this background and as a complementary initiative to 'Our Healthier Nation' and local Health Improvement Programmes that funding for Healthy Living Centres was launched in 1999. £300 million of National Lottery Money was made available to fund 351 Healthy Living Centres across the UK within the most deprived areas of the population. The main aims of Healthy Living Centres were that they would help people maximise their opportunities for health and well being by addressing health inequalities, with the '3 key elements' being:

- to promote health in its broadest sense;
- target areas and groups that represent some of the most disadvantaged sectors of the community;
- reduce differences in the quality of health between individuals and improve the health of the worst off in society.

(New Opportunities Fund (NOF) information for applicants)

There were no constraints on what form a HLC should take, as the main emphasis in line with policy thinking was that there should be innovative targeting

of the service to the particular needs of their community promoting health and well-being in its widest interpretation as defined by the World Health Organisation (1979) as 'a resource which gives people the ability to manage and even to change their surroundings'. Hence a Health Service Circular (HSC 1999/008) explains that *Healthy Living Centres can include a range of models and are most importantly about initiatives, partnerships and networks rather than bricks or mortar*. Indeed as Hills et al (2007) explore the common theme that runs through HLCs including Lincolnshire Probation's is that HLCs successfully developed 'platforms for innovation'.

3.2 Lincolnshire Probation Area – Healthy Living Centre

Lincolnshire Probation's successful bid for a Healthy Living Centre represents one of the more unusual 'models' of Healthy Living Centres with most of the Healthy Living Centres being based in geographically marked 'communities'. The Criminal Justice System, like the National Health Service had, however, acknowledged through Government policy and national research that the causes and redress of offending and crime are linked to multiple social and economic problems that are often beyond their immediate remit. Indeed the Social Exclusion Unit (2002:123) in its Report on reducing re-offending reported:

'Of the range of services that can have an impact on prisoners, only the prison and probation service have a target related to them. However, the social exclusion of many prisoners results from a lifetime of service failure, and it is entirely unrealistic to expect that this can be remedied by the correctional services alone.'

A cataloguing of 'service failure' was identified by Mair and May's national survey of 'Offenders on Probation':

'Most respondents were not working and dependent on state benefits; they had difficulties in paying bills, were poorly qualified educationally and not particularly healthy. There is little doubt amongst criminologists that such factors are associated with offending although the precise relationship between them remains unclear. Their presence cannot, therefore, be ignored by probation officers and much

probation work is focused on trying to alleviate the problems caused by such characteristics.' (1997:p66).

Whilst research of offenders' health needs within the community remains limited in recent years there has been an increasing evidence base of offender health needs particularly within the prison environment and ex-prisoners, which has consistently catalogued the poor access of offenders to mainstream and preventative services and their inequalities in terms of health outcomes. They have also highlighted the shared pathways between health and offending in relation to issues, such as drug and alcohol misuse and mental health, which has been translated in part into the scoring of criminogenic need in probation's Offender Assessment System (OASys; 2002).

One of the most instrumental reports was that of the Social Exclusion Unit (SEU 2002) which as seen reviewed the high level of re-offending (58%) against a background of unmet need; *'many prisoners have poor skills and little experience of employment, few positive social networks, severe housing problems, and all this is often severely complicated by drug, alcohol and mental health problems'*. The report identified that despite heavy levels of need, *'many prisoners have been effectively excluded from access to services in the past'*. It was, for example, estimated that half of prisoners had no GP before they came into custody, despite the following statistics quoted in the report:

- 72% of male and 70% of female sentenced prisoners suffer from two or more mental health disorders, compared to 5% men and 2% of women in the general population;
- HIV infection of adult male prisoners is 15 times higher than in the general population;
- Hepatitis B and C infection of female prisoners is 40 and 28 times higher than in the general population respectively;
- 46% of sentenced adult male prisoners aged 18-49 reported having a long standing illness or disability;
- 3/5ths of male prisoners and 2/5ths of female prisoners admitted to hazardous drink problems.

Similarly, whilst the Home Office has indicated that one third of crime can be linked to the purchase of heroin/cocaine, the report found that many prisoners have never received help in the community with their drug problems. The reception officer at HMP Manchester, for example, estimated that 70% of prisoners came in with a drugs misuse problem, but that 80% had never had any contact with drug treatment services.

On discharge the SEU equally found an absence of follow-up of support for treatment that may have been received whilst in custody. Burrows et al (2002) for example, reported that only 11% of drug using prisoners who received treatment whilst in prison had an appointment with drugs agencies post-discharge.

Quite alarming statistics that were published at approximately the same time was Sattar's (2001) work for the Home Office which revealed not only the higher mortality rate for offenders than the general population, but that those offenders in the community had a higher mortality rate than those in prison:

Death rate 1997:

449.5 per 100,000 offenders in the community

189.8 per 100,000 prisoners

258.8 per 100,000 general population

Often deaths were seen to occur just after release with 50% occurring within 12 weeks of release and 75% within 24 weeks, the main causes being suicide (22.3%) and 46% drugs and/or alcohol. The paradox therefore is that as with Biles' (1994) Australian study the offender in the community potentially has more health risks and less support than those in prison: *It is obvious that custody notwithstanding its well known dangers and short comings, has the effect of reducing or eliminating some of the hazards that confront adults in the general community ... Also in prison, there is less opportunity for illegal drug use, there are fewer options for suicide, and there is some level of surveillance and medical care, even if less than perfect ...* (Biles 1994:p25.

In the community health problems such as drugs feed into a circle of deprivation, offending and social exclusion as represented in Bennett's (1998) study of drugs and crime which found that almost half of arrestees (46%) who reported using drugs in the last 12 months believed that their drug use and crime were connected. It was not just the link between poor health and crime that concerned policy makers and academics but the overlying layers of inequality as McManus's (2000) consideration of the high level of smoking amongst offenders with 77% male and 83% of female sentenced prisoners being smokers compared with 28% of men and 27% of women in the general population SEU (2002). Hence *'smoking, one of the major public health challenges to the UK is disproportionately represented in the proportion of the population already hardest hit by health inequalities'* (McManus:2000).

Literature and services that pertain only to the health needs and services for offenders in the community are, as the Offender Health Care Strategies (OHCS) found in their review of 5 geographical regions, limited and scanty. Their conclusion nevertheless was that the health needs of this larger offender group were 'likely to be broadly similar to those in prison' (2005:p1), taking into account the reviewed situation that prison can offer for some offenders an opportunity to deal with issues such as drugs and alcohol that have not been tackled in the community for reasons either of service accessibility and availability or individual circumstances.

Mair and May's (1997) sample study of 1213 offenders opened up a broad perspective on offender health and lifestyles, with 49% of the sample stating that they had or expected to have certain long term health problems or disabilities listed on a show card, with long-term described as at least 6 months. One third also stated that their health problems limited the amount of paid work that they could do. Overall the report concluded that there was a high rate of self-reported health problems comparable to offenders in prison and higher than those found in the general population.

In studies of young offenders such as Dolan et al's (1999) sample study of the health needs of younger offenders appearing before a Manchester Court

(August 1992), of the 192 subjects interviewed 19% reported significant medical problems, 41.6% admitted to using either alcohol or illicit drugs and 7% had experienced mental health problems requiring treatment. What was particularly interesting about this study and largely absent in studies of offender health is that the report authors have not only reviewed the young offenders' poor health outcomes and statistics, but also parallel attitudes as risk and risk-taking and what that means in terms of providing appropriate help and support to change outcomes:

A high level of dangerous risk-taking behaviour and substance misuse was observed in our sample. A surprisingly high number of the adolescents interviewed were not registered with GPs. ...It would seem that juvenile offenders are not availing of primary care services and their health needs are addressed only on a crises basis ...

Although efforts should be made to redirect these children towards the more usual pathways of health care, their problems are complex and this may prove difficult as they are often poorly compliant, distrusting of authority and have disorganised/absent family support. (1999:p43)

Concerned by the 'dearth of qualitative evidence for the broad health needs of the ex-prisoner population' Salford PCT's Health Needs Assessment of 27 ex-prisoners in Salford (2005) is one of the few studies that seeks to explore the wide determinants of health and perspective that confront those seeking resettlement in the community including employment and accommodation needs. In addition to the 'common health depleting lifestyle factors including smoking, drug and alcohol abuse' central to most offender health studies, other issues pertinent to those in the community, such as poor diet caused by food poverty and poor sleeping patterns with the absence of some structure to the day, become apparent. Given that health needs are balanced in this study against over-riding concerns such as housing and employment and it is an ex-prisoner population it is perhaps not unexpected that offenders interviewed reported that health was a 'low priority' despite their 'poor physical health status,' in comparison to service providers interviewed who still recognised the need for improved services in offender health.

It is against this background of paucity of research into offender health profiles within the community that Lincoln's HLC is provided with an exceptional research opportunity, both to understand more about the health needs and perceptions of offenders on probation as opposed to the prison community and the structures, processes and models of service delivery that seek to meet their needs. As the OHCS found in 2005, 'In general the concept of offenders was very much prisoner and ex prisoner orientated with difficulty in identifying initiatives that were driven by offenders living in the community (the Lincoln initiative being an exception).' (2005:p70)

Set-up and sustainability

4.1 The Bid

The reviewed literature indicates the very broad gaps that exist nationally in both services and research specifically concerned with offenders on probation. At the local level concern about the health needs of offenders on Lincolnshire Probation was to be translated into the bid for the HLC as the scale of the problems became more apparent. It was not just the health problems in isolation, but how they further impacted on the offenders' capability to complete programmes and take positive steps to inclusion and new opportunities.

Lincolnshire Probation's bid for a Healthy Living Centre developed from a former Offender Employment Manager's particular concern of the impact of poor health and access to health services in relation to the clients' ability to participate in employment programmes. Besides accounts of individual client's health problems which were not being resolved and affecting employment possibilities, a focus group of offenders revealed further evidence of health needs that were not being addressed. One member of the focus group very visibly expressed this by demonstrating his 'manky feet', which he could not 'walk properly on', which forcibly indicated the gaps in offender health care; here was a health problem that should be 'easily' addressed, but the offender then had no GP and the situation remained unresolved.

A snapshot survey of the health needs of Lincolnshire offenders on probation undertaken in December 2001 and facilitated by CORU for the bid further revealed inequities in health lifestyles and outcomes as indicated in the following examples:

- 71% smoked daily
- 17% did not have a daily meal
- 57% did not eat fresh fruit or vegetables daily
- 48% used illegal drugs and 63% of that group stated that their drug use had affected their health
- 26% were drinking more than 21 units a week

- 38% had been seen for depression in the past year, 23% for anxiety and 25% for stress
- 45% were not registered with a dentist

Whilst originally it was intended to obtain 'small scale' funding particularly for offenders in the Approved Premises who then had a situation where 'out of county' residents had no designated GP, it became quickly apparent that there was a greater need as identified in national and local research and growing concerns amongst probation staff to obtain funding for all offenders supervised by Lincolnshire Probation. It was also recognised that partnership was key both to the funding and operation of the project, *'although the service (Probation) is uniquely placed to access all offenders under community supervision within the county, the Probation Service does not have expertise in health matters, hence the recognition of the need to work in partnership with those who do e.g. Health Authority, ... effective partnership working is central to Lincolnshire Probation Services ethos'* (original fund bid). Such 'effective partnership working' had already been initiated in areas such as the Drug Treatment and Testing Orders (DTTO), where the need to reduce offending through substance misuse and address the high percentage of drug misuse amongst offenders had already established links with health and partnership working through agencies such as Addaction.

Hence, in partnership with local PCT executives, Lincolnshire Probation made a successful bid for New Opportunities Funding for a Healthy Living Centre. For the PCTs the Healthy Living Centre provided an enviable opportunity to learn about and access those traditionally considered 'hard to reach' and to relate directly to Lincolnshire's Health Improvement Programme through, for example, smoking cessation, substance misuse and mental health, all of which are disproportionately likely to affect offenders.

4.2 The Vision

Healthy Living Centres as 'platforms of innovation' were not designed as seen in Section 3.1 to be prescriptive in their design and could within a broad remit include a 'range of models', as well as a variety of facilities. Those involved in the project bid wanted

it to be 'not just about physical health', but about health in its most general sense of well-being with an emphasis on preventative measures, such as diet and exercise. In view of the inequities of offender access to services and health outcomes the HLC was particularly designed to reach those offenders who found it difficult to access mainstream services, *'who didn't know where to go'* and who did not feel comfortable, for example, going to a specialised hospital appointment, but would rather go to Accident and Emergency (A&E). Overall, the evidence suggested that *'offenders have a fear of not knowing what to expect and where to go for help'* and that *'the reasons for this non-participation is varied but often include a combination of mistrust of 'officials', previous negative experiences, an ignorance of services that are available and the perceived cost of services'* (original bid).

The central 'vision' and 'values' of Lincolnshire Probation's Healthy Living Centre as outlined in the Second Stage Bid to NOF were therefore :

- To address the physical, mental, social and economic aspects of health and well being of offenders in a holistic manner;
- Counter health inequalities by reducing a specific group (offenders), who experience poor health and social exclusion;
- To counter-act the revolving door or cycle of offenders being disadvantaged in a multitude of ways until social exclusion and further crime becomes a way of life, hence ultimately reducing re-offending.

To achieve this, 2 public health nurse practitioners seconded from the then West and East Lincolnshire NHS PCTs would be based in probation premises, so that health advice and support was easily accessible. The model of the Healthy Living Centre was derived according to the original fund bidders from extending the principle of probation's basic skills courses, in which *'we might not initially get them (offenders) to the college, but we could get the college to them, by providing it on probation premises'*.

Equally the concept of the Healthy Living Centre was

based upon Probation's basic skills model of screening for need and then referral for assessment. All offenders under supervision would have an initial screening by their case manager. If this screening showed that a more in-depth health assessment was required the offender would be encouraged to see the HLC nurse. The nurse may then give advice and information or, where appropriate, suggest referral to external agencies and/or specialist provision emphasising the 'bridging role' of the nurses to encourage and signpost use of mainstream services.

The nurses would also facilitate health promotion/prevention workshops which would be 'advertised/promoted' to all offenders not just those who require a health assessment. Whilst appointments with the nurse and health promotion workshops were stated in the bid to be 'non-enforceable', there was a limited period when those on an Intensive Care and Control Programme (ICCP) and DTTO programme were given one appointment with the nurse as an enforceable part of their order. All appointments with the nurse would be strictly confidential and independent of probation's supervision process.

4.3 Implementation

Whilst it could be seen as an unprecedented opportunity to create a Healthy Living Centre without too many prescribed boundaries, the unusual nature and originality of the HLC meant that there was no other similar HLC, or probation health service to refer to for reference and advice. As one manager reported *'we had no other footsteps to follow'* therefore *'what becomes quickly obvious in the process of set-up is that you don't know what you don't know until you start the process'*.

Without a blueprint there could be real creativity about the structure and delivery of service, but much also had to be determined such as the nature of the 'clinical rooms', recruiting nursing and administrative staff and determining all the documentation such as the case manager's screening form and the nurses' assessment form. Financial and personnel systems which had to cover different systems within probation, health and Lincoln University had to be devised to make the partnership a reality. As the Bridge

Figure 9: The Healthy Living treatment room at Grantham Probation office



Consortium consider in their final evaluation of HLCs (2007) one of the overlooked achievements can be implementation itself in the challenge and time of setting up a HLC, developing it and, in the Lincolnshire Probation HLC's case, leading it to a sustainable future.

Whilst the project began in February 2003 there was only the project manager in post with recruitment of the administrator in the June and the two nurses in the following autumn. Building up a service that most reflected the needs of the client group was the overriding priority. With regard to the nurses, for example, a decision was taken that they would not wear a formal uniform, which was intended to break down any potential barriers.

4.3.1 Rooms

Although Healthy Living Centres were not about 'bricks and mortar' the bid had determined that there would be designated 'Treatment' rooms at Gainsborough, Louth, Spalding and Skegness where health assessments could be carried out by the nurses and Clinical Rooms/Nurse's Resource Rooms at Lincoln, Boston and Grantham where 'treatment' such as immunisations/packing an abscess could also take place. Setting up of the rooms was seen to be not only a practical and visible representation of the HLC within Lincolnshire probation, but also according to a manager 'very important as they dictate what we can do'. The offender could 'walk down the corridor' and have 'treatment' rooms to deal with his/her physical

health needs, such as Hepatitis C immunisations, as much as signposting to other services. This was seen to be preferable particularly as the use of outside health clinics by the HLC nurses in the beginning of the project was characterised by large numbers of non-attendance.

The organisation of clinical rooms however, was to prove much more difficult than it appeared on paper, with one manager comparing it to wanting to 'build up a heli-pad in a built-up area just because you wanted 'a room with a sink and a couch'. As the Interim report relates (Jackson, 2005) organisational changes within Lincolnshire Probation, with the closing down of certain offices and the refurbishment of others meant that plans for treatment rooms had to be adjusted according to practical constraints, with only Lincoln and Grantham having 'nurses' rooms' as illustrated in Figure 9.

The programme of activities and the nature of the service delivery, as will be discussed in Section 5, was nevertheless seen as the key indicator to the service and 'what works', not whether the client was seen in a 'clinical' room or a probation interview room, although the former still provided a wider choice for the service. Moreover, given the large geographical location of the service its development was based on a more peripatetic service where the emphasis was on a service being brought to the offender, whether in a variety of probation premises or in for example 'unpaid work' locations.

4.3.2 Personnel

The HLC has also developed its own concept of roles, with the appointment of a PSO in 2005 rather than a nurse, who has taken responsibility for various health promotion workshops for offenders, the arrangement of gym passes and tutoring the pilot Low Intensity Alcohol Programme (LIAP) which has had a positive effect on offenders' knowledge about the effect of alcohol and reduced their intake.

As both Hills et al (Bridge Consortium 2007) and Platt et al (2005) have considered in their respective national evaluations of the HLC programme in England and Scotland, the recruitment and retention of personnel who have a desired skills mix has been an issue of concern for small HLC teams. For the HLC it has equally been an important part of how the project has developed the service and its outlook.

From its inception in February 2003, only the Researcher and one member of the original steering group remain in the project. The HLC being a part of an ever-changing landscape in terms of its personnel and organisational background as change was effected both in probation and the PCTs. As a small team which has had a demanding role to set up, innovate and sustain a new service, the service was considered by a manager to be 'very fortunate that those appointed could cope with a great deal of flexibility in their circumstances' and brought appropriate skills to the project. Given that the project has had 5 project managers, (two of which had two separate periods of management), 2 changes of nurses in the north and south of the county and two different administrators; the project has nevertheless remained robust and innovative in its services to offenders. Whilst personnel were important in a small team, the gradual set up of processes and the service model meant that the project could survive and evolve with benefits from the skills and energy that personnel brought. Over the last eighteen months the team has remained unchanged and with its present project manager has had time to consolidate and review its sustainability.

4.4 Sustainability

The sustainability of the HLC has been a key feature of the project, that as much as building up the service

model, the HLC reviewed funding opportunities from an early stage, so that the innovation that had been initiated could be sustained and grown in the future. For the HLC the case for sustainability was recognised in its ability to address health inequalities within a particular part of the community that has poor health outcomes and lifestyles, as reflected in both Hills et al (Bridge Consortium 2007) national evaluation of the HLCs and Offender Health Care Strategies' (OHCS 2005) review of community health initiatives for offenders:

'For NHS and other statutory bodies considering... continuing to fund existing projects, there is a case to suggest that the additional costs of providing these interventions may well be outweighed by future reductions in the demand for health care treatment at both the primary and secondary care level. Some of these interventions would traditionally be provided through the NHS e.g. lifestyle advice, and HLCs may provide a low cost alternative that vulnerable members of the community may be more willing to engage with.' (Hills et al 2007:p132)

'The health needs of offenders is not an explicit NHS priority. However, successful initiatives to identify and address the complex health needs of offenders and their families will make a major impact on reducing health inequalities – which is an NHS priority.' (OHCS:p72 2005)

The distinctive health model that the HLC developed and its integral role within probation providing for offender need, which provided the platform for sustainability, is considered in the following sections.

Service model

'We will support the piloting of a first reception healthcare screen within approved premises and probation offices e.g. to identify risk of self harm, any healthcare problems requiring immediate medical attention and facilitating sign posting to appropriate services etc.' (Improving Health - Supporting Justice DoH 2007:p35)

'...For many people, although they often understand the harm involved in changing their ways, the apparent insurmountable problems in doing so lead them to think that healthy choices are simply not for them. Lectures from distant national bodies and worthy exhortations to change from well intentioned organisations with seemingly weak connections to the realities of everyday life can become irritating reminders of these negative feelings about health...Initiatives to increase demand for healthy choices need to be matched ... with support that fits with individual needs on the ground.' (Choosing Health DoH, 2004, p.105)

As the quotes above demonstrate, whilst research into community offender health needs has been limited, as seen in Section 3, there is an increasing recognition both within the criminal justice and health systems that if health inequalities and exclusion are to be addressed then there is a need for innovative services structured at local levels of community demand. What is radical about the HLC is that in terms of 'service appropriateness' it has already 'piloted' and developed a distinctive model of care to meet the specific needs of the offender client group. The model will therefore be explored throughout the rest of the report from the perspective of all its main stakeholders, namely the Healthy Living team, probation staff and most importantly offenders to review the processes that surround the structures of delivery of services and its impact and the views and responses of those involved.

5.1 Alternative Health Model

The following review of the HLC model is based upon both observation of the HLC and formal and informal discussions with the Healthy Living team. Interviews have been undertaken over the project with past and present project staff including project managers, administrators and nurses. Given the

central role of the nurses in the development of the service there have been 'updated' interviews with two of the nurses.

5.2 Setting of Service – Time and Flexibility

Over the period of the project the Healthy Living Team considered that service characteristics had been developed to provide a service that was most appropriate to client needs, to both address immediate health concerns and signpost where required to mainstream services.

The setting of the service in probation premises was seen as particularly pertinent, with the changing of the usual health model of the user having the onus to seek health advice and information, with the HLC alternatively bringing the service to the offender.

The fact that nurses can be readily seen on probation premises and have an appointment that combines with seeing their case manager was seen to be an important factor in making the service as accessible as possible, given that offenders can often have chaotic lifestyles which means that attending a number of appointments in different situations and times can be difficult. Indeed, one of the interesting effects, as already identified in Section 4.3.1 is that the use of outside health clinics both in the initial set up of the HLC and for hepatitis screening and immunisation has resulted in considerably higher levels of non-attendance than when the offender could see the nurse on probation premises.

Flexibility of service, in particular the time that nurses could give for a client's appointment (sometimes up to one and a half hours) was seen to be a significant additional benefit, contrasting with mainstream services and the time limits on a usual GP or health appointment. This was felt to be essential to deal with the multiple layers of need of some offenders, who often due to poor communication and life skills find it difficult to articulate their problems within a short consultation time.

Indeed, whilst the service does emphasise signposting and access to mainstream services, nurses did relate throughout the project that for some offenders it can take several long appointments to get to the 'source of

the problem' and enable the client to access the services they need. As one nurse explained, 'on the first appointment you may get the problem that they have come to see you about, but later there are much more deep seated problems that come out'.

Time by itself would, however, not be enough without the central role of the nurses in providing the support, confidence and empathy, which offenders need to begin to address their health problems. In this respect some nurses reported that clients could appear at first defensive as they were unsure of what to expect and may initially see the nurse as a 'power/authority figure'. It was therefore important to quickly dispel any such preconceptions, and this included the decision for the nurse to wear 'ordinary' clothes, rather than a uniform, so that potential barriers were lessened. Moreover, that the nurses are separately employed from probation and are not in a formal role within a GP or health setting, provides them with a more fluid status in which the offender can 'open up' about health and well-being issues that they might not want to relate either to their GP or case manager. It was this building of trust and confidence that was seen as an essential first step in the client relationship. As one client related about his health and anger management issues to a nurse, 'I've never told anyone about this before – it has made me feel so much better'.

5.3 Personalising the health message

The appointment with the nurse is therefore led by the client with the emphasis on listening closely and seeing 'problems from their eyes', with a lot of 'diplomatic delving' to identify 'what their needs are, not our perceptions of their needs'. Hence whilst the assessment is an important tool of record for the HLC, it may be that the assessment is not completed until a further appointment, or will not be the first thing that the nurse talks to the client about, so that the offender has the opportunity to talk about what they think is important. As a nurse explained, 'The client may, for example, have been referred by a case manager about problem a, but the offender will say that the real problem is problem b'.

This is therefore a service that has already pre-empted many of the *Choosing Health* (2004) report recommendations to move from 'advice from on high

– to support from next door', with its inclusive rather than 'silo' view of the client and their needs:

'In the past many sources of advice have been designed around a single issue, giving up smoking or being overweight for example – rather than taking life in the round. We want to make sure that people can start by accessing advice appropriate to them from one person who recognises their needs and motivations as an individual, not just as a smoker or a person who is overweight.' (*Choosing Health: DoH 2004:p107*)

As one interviewee related, a client may smoke 60 cigarettes a day, but more important may be the depression that is causing the smoking and the further effect that it may be having on the offender's ability to 'cope'.

The holistic nature of the service over the 5 years has therefore become a vital cornerstone of delivery, being a service led by individual client need rather than trying to fit the client around the service. Whilst the service has learnt more about health needs already well researched in the offender population as drugs, mental health and alcohol problems, the service has also looked at the very wide model of health and well-being. Issues such as unresolved bereavement, sleeplessness, diet, lack of confidence and self-esteem have been found in the HLC to be as important issues for improving offender lifestyles as health needs well researched.

5.4 Health Promotion and Change

'Social exclusion involves not only social but also economic and psychological isolation. Although people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know.' (*Saving Lives Our Healthier Nation, DoH 1999:p17*).

'Most clients are threatened not so much by a possible long-term illness – but by the forthcoming health changing activity itself. As such, the nurse is ultimately trying to sell a 'health product' that may appear unpalatable or unappealing to the client. A commitment to modify health behaviour usually equates to the client group having to give up

something that is part of their life style that they most likely enjoy or is part of their daily routine... The change process is often perceived as being uncomfortable. (Whitehead and Russell 2004:p 164)

Both of the above quotes demonstrate as found in the HLC that informing and changing health behaviour is not an easy option and requires considerable time, support and consideration of many approaches as to what may work within the offender community. 'Selling' health promotion is therefore seen as dependent on the exchange of perceived costs for benefits that are viewed as tangible, attractive and accessible both now and in the future. In terms of trying to change behaviour there was a need as an interviewee explained to 'tell it how it is', by giving the offender all the facts, advice and information that they need besides support and reassurance, to enable them to make the changes in their lives for themselves and try to make them see the 'costs and benefits'. 'You say you will feel a lot better – you will sleep better' – as they need the 'positives to hang on to' and also relate the consequences of, for example, alcohol and drug abuse, which will not only affect their health but their ability to stabilise their lives, if they do not change.

Moreover as 'unhealthy' behaviours are routed in daily living, so pathways to services and change could also be dependent on activities that were perceived as benefits, rather than costs. Hence the HLC provided gym membership where appropriate where wellbeing intermingled with a 'fit' image that a client wanted to project.

There was nevertheless a recognition that 'You have to ensure that the client is ready to change behaviour – you can't just say 'this is the service', that whilst some clients had huge needs, their ability to take up the advice and support that the HLC provided is limited until they can act on the advice given. In one case, for example, a client who had problems with bereavement and needed grief counselling had taken nearly a year of support to go to a therapist. *The project is about helping people and what needs to be done to get them there. I have had to work very gently and that is what inequalities are all about – breaking down the barriers very gradually.*

5.5 Advocacy and Access

One of the main barriers to improving offender health outcomes has been that some offenders have been unable or unwilling to negotiate the processes of mainstream services for multiple reasons, such as lack of articulacy, low self-esteem, or general lack of life and social skills of 'how to approach services to get what they need'. 'Advocacy' on the behalf of the client was therefore seen as a vital role of the nurse and one of the Healthy Living Centre's most important outcomes, as they made links with GPs and other health agencies to facilitate offender access to mainstream services.

Sending letters to the GP outlining the client's problems before the offender goes to see them with the client's consent is one of the most common activities in this respect, otherwise they 'get there and can't get their words out', or they 'bottle out' and don't tell the GP what their real concerns are in the limited time of a GP consultation. In this respect, very sensitive issues such as male rape and concerns about HIV can inhibit initiating discussions with a GP, so letters written by the nurses have enabled the offender to go and talk to GPs about unresolved issues affecting their mental and physical health. In the case of one client who had just come out of prison and had a number of unresolved health problems including not taking medication that he needed to prevent fitting, there was a concern that if he did not access services he would 'end up dead'. The nurse therefore wrote a letter on his behalf to the GP and his father agreed to accompany him as he 'didn't know what to say'. The GP was 'very helpful' and then saw the client once a fortnight to ensure that he was taking the appropriate medication and the nurse saw a 'very visible change in him... Before, he could hardly sit upright'.

Interviewees equally related how in instances where clients had been 'struck off' by the GP practice that they would support the client to be re-instated. For one client this meant liaising with practice staff and working through the reasons for the break down in the GP-client relationship due his anger and anxiety which resulted in the client sending a letter of apology. The client was re-instated on the GP's list and he could then continue with medication for chronic

arthritis and probation group work. In certain instances the nurse has accompanied clients on health appointments in situations where the client has been particularly 'distracted' and when without their support and intervention they have considered that the client could neither have accessed nor got the service support that they required.

5.6 'Platforms of Innovation'

As 'platforms of innovation' what HLC personnel have found to be central to its development as in the experience of other Healthy Living Centres is that they have to constantly develop and 'experiment' with 'what works'. Indeed, in seeking to create a service most appropriate for offender needs meant having to learn in instances not only 'what works', but what does not work as well. In the earlier stages of the project, for example, attendance at workshops was considered to be particularly problematic, as a project manager's report in May 2005 related, 'Workshops continue to be problematic in terms of attendance e.g. in the last month we have arranged 3 dental workshops with specialist leaders and have had only one attendee...'

The cause of the low attendance was seen by interviewees at the time to be due to a number of factors. Firstly the erratic lifestyles of some offenders, and the fact that workshops were not necessarily combined with visits to the case manager as for as individual nurse appointments, meant that they were likely to miss the workshop. Equally, they preferred the one to one sessions with the nurse and did not want to necessarily discuss general health issues among an unknown group of people. Hence some of the more successful workshops were seen to be amongst those groups that already existed, as for the then DTTO and ICCP clients where a rapport and group dynamic could be facilitated.

In the latter part of the project and particularly with the appointment of the PSO to set up and promote LIAP and the wide range of workshops offered in relation to offender need, the attendance and effectiveness of workshops has been seen to significantly improve. The emphasis on bringing the workshop to clients on topics researched to be most appropriate to their expressed interest and need, has been seen as a more successful strategy of targeting a

wide range of clients. Providing workshops for Unpaid Work clients on site or at the Approved Premises, or manning 'stalls' at the entrance to probation premises has been seen as a much more successful way of reaching some of the client group, than booking a room for no-one or very few to attend. The use of alternative ways to foster well-being, such as chair massage and relaxation workshops has also been well received by the client group.

5.7 Legitimacy of small steps

'It is widely acknowledged that gathering evidence of impact from complex community interventions of this kind is a challenge. A key lesson from this programme has been the importance of understanding the outcomes and impacts at a number of levels. For example, evidence of impact in terms of enhanced health and wellbeing for individual participants has to be set against an understanding of how effective the HLCs have been in engaging sections of the population who might not normally take part in health related activities.' (Hills et al, Bridge Consortium 2007:p8)

As Hills et al noted in their national evaluation of HLCs, 'gathering evidence' of impact in 'complex' services such as the HLC has not been an easy process. Indeed, given that the HLC operates at many different levels to meet the individual and very varying needs of the client group, 'success' has not surprisingly been viewed throughout the project to have many different layers of meaning behind the outputs that could be statistically measured. It may also not only be the health output/outcome per se, but the very important step that it has required on the behalf of the client to change behaviour or access a service that is just as significant. As Julian Corner, Director of the Revolving Doors Agency has related in his presentation to the Offender Health Research Conference at Manchester in January 2008, providing a culture similar to the HLC in which acknowledgment is given to the realistic and 'small steps' taken by offenders to change their lives is an important building block to change in their future.

As an example, nurses have explained to clients that whilst giving up smoking is the ideal situation, reducing smoking levels or stopping smoking around their

families is an intermediate 'target' that can be treated as an important step and one of 'success'. The evolving team were also aware that a large number of offender health problems as drug and alcohol misuse and smoking often have cyclical patterns of relapse, where 'success' is not a necessarily linear process. The motivation of the individual and particularly if they were at a 'point of change' is an important factor in the varying impact of the HLC, for individual behaviour changes are the basis of many of the outcomes of the HLC. As an example, a nurse explained the limitations that sometimes occurred to acting as a 'change agent' when a client who had really bad dental problems and was therefore susceptible to dental infection still did not access treatment when given help to sort out these issues.

The HLC team nevertheless reflected that whilst some clients may not yet be in a position to act on the advice and information given and remain 'hard to reach'; they had been made aware of health problems and the options of how this could be addressed in the future. Overall the HLC was easing access to health care and reaching some 'desperate' clients who had previously had a 'lifetime of falling out of the system'. For some this would mean finding out potentially life threatening conditions such as a punctured lung or high blood pressure, for others it might mean starting to change diets, do more exercise, cut down on alcohol or smoking. Success was therefore viewed as multi-layered based upon a flexible and innovative service that listened to client's needs and provided them with the 'space' to change at their own pace.

Role within Probation

As has been seen, the Healthy Living Centre developed from a need identified within Lincolnshire probation staff. In parallel with other research and developments within the criminal justice system there was an increasing recognition that to achieve compliance with the probation order and reduce re-offending it was, as Harper and Chitty (2004) relate, the 'dynamic' risk factors that had to be addressed:

As static risk factors, for example, criminal history cannot be altered; it is through changing the dynamic risk factors, for example, education, employment and substance misuse, that future offending can be reduced (2004:ix)

For the HLC project team, meeting the requirements of the service's customers was as much about supporting the probation staff in their supervision role, as it was individual offender health needs. The aim of discussions with probation staff including interviews with referring case managers, Approved Premises staff and those responsible for programmes was consequently to understand what role the HLC had developed within probation within its widest context in terms of the processes, role and outcomes of the probation service.

6.1 Integration

All probation staff interviewed indicated their support for the project and how it had become integral and embedded in their supervision of offenders, not an 'add on'. Indeed, that the presence of the HLC in probation premises had 'prioritised health' and provided a 'cultural shift' in the management of offenders where previously there had been a 'great empty hole in the criminal justice system'. Before the HLC, case managers reported that health was not an issue they would necessarily have asked questions about, unless there were obvious correlations to offending, such as drug and alcohol abuse. Going through the health screening and referral forms of the HLC now provides a diagnostic mechanism which 'opens up' discussions and avenues about how to address their health needs. As a case manager explained *'it gets them talking about things that they are stressed about, which is really helpful to go through with the offender at the beginning of the supervision.'*

While Probation's OASys review of an offender's risk and needs does include Section 13 on 'health and other considerations' this was not seen to provide the same comprehensive basis for discussion of health, as it is a restricted tick box that relates mainly to the offender's ability to attend different appointments and engage in various programmes. Hence the view was that the HLC's specific health screening tool was essential to extend the limited assessment of Section 13 into a more informed and 'dynamic' profile of offender health needs which could become part of supervision planning.

Most of those interviewed considered that the screening and referral system is not time consuming to complete. However, one case manager did reflect that in some instances the screening form could be more 'user friendly'. As an example the offender might want a dentist, but when they were asked all the general health questions on the form they start to 'turn off' and have to be reassured that they can see the nurse for a specific problem, not all the issues listed.

All of the case managers stated that they recommended and 'sold' the HLC to 'everyone', as a 'valuable service' and encouraged them to attend. There were nevertheless varying opinions amongst case managers as to which offenders they considered were most appropriate to attend. An interviewee related that if an offender had health needs that were 'criminogenic', such as drink and drug problems, they should see the HLC as a 'matter of course', compared to issues of more general health, such as dentistry, which, although important, could be 'sidetracked' as they were 'not linked to offending'. Contrarily other case managers reported that where the screening had indicated that the client did not have a GP and dentist, they were seen as particularly important to refer, regardless of perceived criminogenic need.

'Selling' the HLC was seen as essential for most offenders regardless of individual need, as they were often apprehensive of what 'to expect', or did not want to address their health problems. As a case manager explained of their promotion of the HLC *'look this is what we can offer – you don't have a GP, you don't have a dentist – this is what you need'*. Others simply emphasised the very informal and friendly

nature of the service, as *'they are very nice people to pop along and have a chat with'*. There was a requirement to be 'constantly battling' and offer 'positives' to motivate and reassure them to attend. One client, for example, was very apprehensive about going to the HLC and had to build up 'reassurance' that the nurse's consultation was totally confidential from the probation order. Similarly a case manager stated that they liked wherever possible to 'introduce' the client to the HLC and the nurse before they were officially referred. This they felt was important to make them 'aware of the process' before they attended, which they felt made for a much more 'positive relationship'.

Time was also seen as an important factor in referring. It might be that offenders are not referred at the start of their order; even if they are screened, for there was a desire not to overwhelm the offender in the beginning with a number of appointments which they would not keep and 'set them up to fail'. Compliance and building up motivation to attend was therefore from this perspective the 'first' priority before referral to the HLC.

6.2 Resource

All those interviewed reflected that the HLC filled a resource gap for both probation and the offender; for although health had been recognised as a need as part of the supervision, until the HLC many health problems had to remain *'swept under the carpet'*, as often there was the feeling that *'you couldn't do anything about it'*. As interviewees explained, this was both because they were sometimes unsure on how to advise the offender and how to ensure that the offender had the opportunity to take the advice.

Firstly there was the consideration that a large percentage of their clients did not have GPs (16% of those screened in Year 5) and if they did *'you had to chance they would sort it out', 'the pressure was off once they left the building'*. Moreover, that there were many issues of physical and mental health that the client would not want to disclose and discuss with their case manager, but could do within the confidential appointment with the nurse. Whilst partnerships with other health organisations existed and GPs had been consulted on offenders' health issues, this did not

compare to the ease of getting specialist health advice and support from someone connected to an in-house service either at the 'end of the corridor', or the telephone.

Over the 5 years of the project the HLC has changed perceptions and improved confidence to deal with a wider range of health issues that may previously have been recognised, but there was an uncertainty of how to 'sort them out'. As an example, an interviewee related that when offenders had previously talked about sleeping problems, bereavement, or self-harm issues, they *'didn't know how to really help them'*, but now they could refer them to the nurse for advice and signposting if required. Indeed, the researcher has observed on many occasions a case manager coming to ask a nurse an informal question about a particular health problem or service.

Concerning issues such as 'lower severity mental health problems' this has been particularly important, for whilst there is a high prevalence amongst the client group (44% of screenings), it was in these 'grey' areas such as anxiety, stress and/or depression that case managers reported that they found difficulty defining and accessing the right service for the client. Within approved premises, for example, where management of clients is on a daily basis, there were concerns amongst staff who had not been trained to 'deal with mental health issues' that there were often 'borderline' cases where the client had not been diagnosed before release from prison and they *'struggled to access the appropriate services for them'*. The role of the nurses was therefore essential in such situations; *'We need someone to just say is this behaviour normal and OK, or do they need more serious help?'*

As the service has developed so has staff knowledge, as in the case of the HLC's introduction of Hepatitis B and C screening and Hepatitis A and B immunisation, in which some case managers realised that they needed more advice from the nurses as they were not aware of the risk factors, or its prevention. As one case manager explained, *'I wanted some advice on Hepatitis as I know that a number of the clients have Hepatitis and are at risk but I didn't know really what they were talking about, how is it passed from one person to another, what is available to the offender?'* Increased knowledge of health issues and

the provision of an online health directory of services by the HLC equally meant that those clients who did not choose to access the HLC could still receive more informed advice if required from their case manager:

The professionalism of the nurses and their connections to wider health networks were seen as invaluable to clients' access to services that probation staff were unsure how to access, or which due to pressures of time and case loads, would have taken longer to negotiate. As interviewees explained they did not always have the time to be on the phone for half a day to find out what the appropriate service was or who they should speak to about a particular clients' health issue. Equally, they felt that the nurses have the 'authority' and knowledge to ring up about a particular client and explain the case to another health professional. This could both speed up processes and 'open' doors of access as explained by one case manager who related how a nurse's intervention to get an alcoholic client into hospital treatment and 'then sorted out' after discharge, would have been a much more difficult and long process if 'I had had to negotiate'. The HLC provided an 'easy bridge' between 'us and health, GPs and hospitals'. The time therefore taken up in completing the screening and referral forms was seen to be outweighed by the many benefits in time and support that the advice and signposting of the nurse provided.

6.3 Holistic Service

Probation staff therefore considered that the HLC had developed a distinctive and flexible service most appropriate to the client group and the probation order, as reflected in the diverse subjects and locations of workshops in response to user need and requests by case and programme managers. Moreover, the positive feedback given by clients following individual assessments reinforced that here was a 'friendly face' that they could 'trust'. Given the large number of service providers that an offender may see in his/her life this was not seen as *'just another stranger muscling in on their lives'*, but someone who treated them as an individual, not just as an offender.

Of importance was the 'holistic' nature of the service that could offer extra support for those offenders who were already seeking to address health and

criminogenic needs through, for example, drug programmes and agencies. For whilst the partnership between treatment agencies 'work well', the boundaries of care are necessarily treated in a 'silo' and limited by service parameters. What the HLC provides therefore is a multi-dimensional tool of support where offenders can 'discuss all their issues'. As well as 'counselling' support for drug treatment and programmes, staff welcomed, for example, the help that nurses often provided in gaining client access to dentists (66.2% not registered with a dentist in Year 5) given that abscesses and the wearing down of teeth was often a consequence of drug misuse. In reference to LIAP it was seen that the HLC could provide for a gap in alcohol services in the county having a positive effect on those offenders for whom alcohol was a contributory factor to their offending behaviour:

The HLC was equally seen as an alternative service or 'bargaining tool' for those offenders who were not yet in a position of change regarding issues such as drug and alcohol misuse. As an interviewee explained the HLC could therefore act as a 'half-way house' for clients, *'between accepting that they have a problem and taking responsibility for it'*. Initiatives of the HLC such as gym passes and the provision of weekly fruit at the Approved Premises were seen to provide important opportunities to support change in health patterns by providing support for everyday. Improving health literacy by designing leaflets specifically for the client group, such as the 'Food First Aid' leaflet was equally seen as a very practical step to overcome gaps in health knowledge and awareness given that offenders generally have poor literacy skills. Overall there was a view that whilst many of the clients' health needs are entrenched and long-term, it has an essential support role in 'chipping away' at a client's health and related social and offending problems.

6.4 Compliance and Rehabilitation

Given that compliance with the probation order, the rehabilitation of offenders and consequential reduced re-offending are the central objectives of the probation service, probation staff reflected on the contribution that the HLC made in these aspects.

Whilst attendance at the HLC could be erratic as for other probation programmes and appointments given

the chaotic lives of some of the clients, that attendance of the HLC was in itself voluntary was seen as a positive step for many offenders. A case manager, for example, related how one client who they had found 'very difficult to engage' and failed to attend most of their probation appointments had seen the nurse on his own volition every week, missing an appointment only once. Such 'anecdotal' evidence highlighted that for some clients the HLC was the 'hook', which enabled engagement with the probation order. There was also the view that it was beneficial to the probation system and the offender that regular appointments with the nurse were attended without the need for the case manager to continually direct the offender, that they are 'keeping appointments within the system, without my intervention or influence'.

Health itself was seen for some offenders as the paramount need, 'the only thing that's in their way to re-integration and eventual stopping re-offending'. As related to in Section 6.2, those particularly with mental health issues were often seen as difficult to 'manage' with their emotional well being 'getting in the way of them really being able to complete their order'. An issue reflected on at a national level by Harper and Chitty:

'...Mental health problems are likely to impede the ability of both prisoners and probationers to access and properly engage in offending... related programmes... The likelihood of them committing new offences is determined not only by their characteristics but also the intensity and quality of supervision and treatment they receive when they have access to the community...' (2004:p64)

Interviewees further considered that it was not just in relation to established criminogenic health needs, such as mental health, drug and alcohol misuse that health played a role, but that poor eating and sleep patterns, low self-esteem and a general neglect of 'looking after themselves' had an impact on the effectiveness of the probation order and the opportunity for rehabilitation as represented in their following comments:

'If you have poor health you have a lack of motivation to address your offending and the other issues in your lifestyle that affect it. They (offenders) are also more likely to miss other appointments to help them in other areas.'

'If a client has physical and mental health needs and is depressed then they will continue to make 'poor decisions' that is likely to lead to re-offending. They won't start to sort out their problems.'

'Health is definitely linked to offending – if you don't feel good about yourself then you are not going to address all the other issues that affect offending. If you help them feel better about themselves that is very important.'

As an interviewee explained, just 'asking' the nurses to get some offenders to 'start caring more about themselves' in relation to personal hygiene could be the first important step to change, for if they remained 'smelly', it was difficult to integrate them into group sessions and eventual employment. Similarly, offenders who are not eating and sleeping properly and attending programme courses could be 'fidgety and argumentative' with 'poor concentration' and lack motivation to move forward in their lives.

Over the 5 years of the project probation staff have increasingly found the HLC to be integral to the probation order and have supported its sustainability to long-term funding as in participation of the Health Inequalities Impact Assessment (2008), advocating that health advice and support should be part of the umbrella of holistic services offered to the offender. Though 'effectiveness' of the HLC at an individual level varied considerably in relation to the complexity of the health needs of the offender and the ability of the client to respond to the opportunity provided, it nevertheless was a platform to change behaviour and lifestyles. In line with research undertaken on OASys data and McGuire (2002) on multiple criminogenic needs, 'what works' is a multi-modal approach to interventions, of which support for health is one of the main responses in breaking down the revolving door of exclusion.

6.5 Developments?

The project – not unnaturally – during its five years has highlighted more resource gaps that are central to the settlement of offenders, particularly in relation to mental health and well being. For whilst the nurses have acted as important 'stepping stones' to mental health services, some probation staff still felt that there was a need for more input and expertise from, for example, Community Psychiatric Nurses who could assess the very 'borderline' and complex cases that take up a lot of time and access the most appropriate services for them.

Equally one development that was considered by probation case managers was the provision where possible of drop in sessions as, given the characteristics of the client group, some interviewees felt that once you had got them to commit to seeing the nurse to discuss a particular health problem, you needed to have them seen there and then. Otherwise, whilst they wait, the 'moment' may have 'passed' and they either lost their enthusiasm, or due to their erratic lifestyle never turn up.

The HLC has demonstrated that more training in health issues is required for probation case managers both as part of their induction and continual staff development. For the offending community and particularly those who still do not access the health services or the HLC, they are often a first resource for screening and signposting a range of problems from sores and dental problems to more complex mental and physical needs.

Offender health

Given the noted limited research that includes the views of offenders on health structures and behaviour it was important to review not only their contact and experience of the HLC, but to understand more about the wider issues and perceptions that underpin offender health profiles. As seen in Section 1.2, a variety of methods was used to include as many offenders as possible in the research process. This section therefore reflects on the quantitative and qualitative data obtained from semi-structured interviews, focus groups, the Offender Health Survey (Jackson 2007) and follow up surveys. The fieldwork explored reflects not only on the service of the HLC and what offenders consider to be its 'added value', but their perceptions of health and health behaviour and the relationship of health to offending and the criminal justice system.

7.1 'Added Value'

7.1.1 Taking Time

The time allowed for an individual appointment was particularly valued as an important factor of the service that allowed the client the opportunity to express sometimes a multiplicity of concerns and resolve problems compared with the time limits of a usual health appointment and particularly that of the visit to the GP. That the service has the flexibility to spend as much time as necessary with the client, which on occasions when required can be even longer than an hour appointment:

'...The nurse has got time to listen to me...with the GP you spend more time waiting to see him, than the time to actually see him, you are in and out in 2 minutes. Then all they do is say 'yeh, yeh blah blah...give you a prescription and a piece of paper... They don't really sort you out...'

'You don't have to get past the receptionist and then have 5 minutes with the GP to just pick up some medication, with all your issues still to resolve.'

'... I couldn't talk to a GP like this. You have only 10 minutes so you can't go into depth about things. There is not enough time to talk about your problems.'

'...If you go into the GP's all you get is a few minutes of time and then they want you out. Where is the next patient? I spent 3 and a half hours talking to the nurse and you couldn't do that with a GP.'

'... With the NHS it is in and out, see as many as you can as quick as you can.'

7.1.2 Rapport

Reflections on the service were dominated both in offender surveys and discussions in interviews on the 'cosy', 'friendly', 'calm' and 'relaxed' nature of the service which was based on an 'easy' rapport with nurses and workshop staff, as represented in the following sample comments:

The nurse is very sociable and nice, confident

It's (HLC) cosy and friendly and comfortable

Very helpful, friendly and accessible

Easy to get on with and a relaxing environment

Calm friendly service which I enjoyed. Very personal service.

In this distinctive atmosphere clients felt that they could have 'open chats' and ask about or discuss any issues that they wanted to, compared to what they described as the more 'closed chats' with a doctor or other health professional:

'I could go and talk to the nurse about anything that was bothering me – even if I had a wart on my willie. I would have no embarrassment or difficulty about talking to the nurse about it. It really helps to have the time to talk through your problems. In fact when I am talking to the nurse I forget that I am talking to a trained nurse, its just as if I am talking to someone I have known for a very long time, so I can talk about anything I want. There are no barriers as they don't wear a uniform or anything like that...'

'I can speak to the nurse all the time and ask questions, which eases you... This is not something that I would do at a GP.'

'The nurse ... is an amazing listener and this is what I need.'

'The HLC is a very different service. Even when you talk to a HL nurse it is so much different to talking to a nurse at a GP, it is like being on a conveyor belt there.'

For those clients who visited the nurse on more than one occasion there was also the advantage that compared to a busy GP practice the nurse 'can remember talking to me about issues', so they 'do not have to go back through it all again'. In some cases clients who had taken partners or family members to the nurse's appointment valued that they could be involved too; 'I have been able to take my partner with me to talk through the problems, which has been very important, so we can talk about health issues to do with us both.'

Being 'listened to' and the personalisation of the service was therefore seen as a vital part of starting to identify health 'problems' and how to deal with them as clients reflected:

'You need counselling and someone to talk to about things, as much as you need medication.'

'They listen and take people's needs into account.'

'It is a great service because it is able to change how you think about things. You think that you are in control but then understand that you are not. You can talk through feelings and understand them more, that you have to communicate.'

7.1.3 Personalising Health Messages / Motivation for Change

In practical terms the provision of information and support in getting, for example, a GP, an emergency dentist, or getting to a gym was seen as invaluable in easing access back into services and giving you a 'push in the right direction' back into mainstream life, 'they give you the choices, the advice, the telephone numbers'.

For those offenders who had a good relationship with their GP the HLC was still seen to provide 'another angle on things', to provide health advice and

information and support in issues where change is required in individual behaviour, such as smoking and alcohol misuse.

As clients described, the HLC was seen to provide 'support without control':

'They get me on the scales and take my blood pressure and keep nagging me about my smoking without telling me what to do.'

'They (nurses) don't bombard you – otherwise you would probably be more defensive and go against them.'

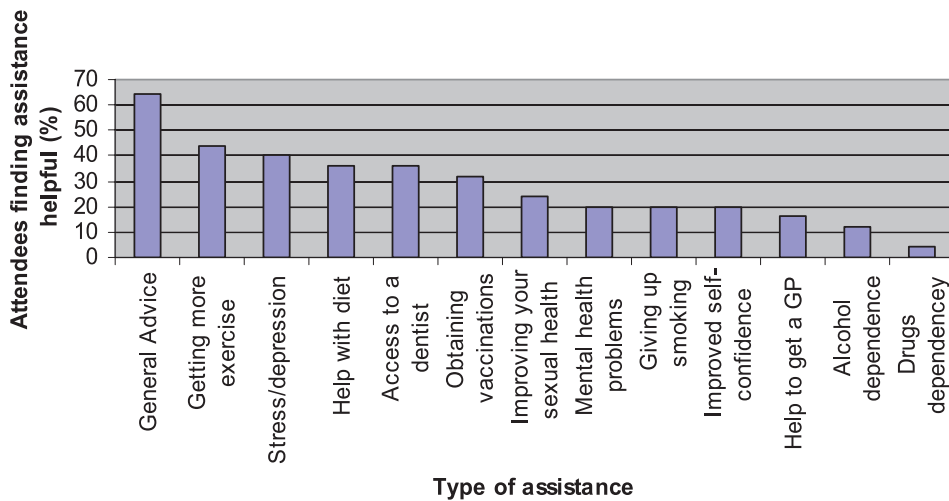
'I found out things that I wasn't aware of. I put the leaflets about healthy eating/nutrition in the drawer – but have now got them out later and am reading them and acting on the advice.'

In terms of smoking, for example, where there is a high prevalence amongst the client group (84% over all years), interviewees related how they needed the nurse's support and encouragement besides aids such as nicotine replacement therapy and stress relievers, 'as without it you tend to give up', 'you think, you're fine, but you're not'. In this respect, one client has managed to reduce his smoking from 80 cigarettes a day to 10. For others being made aware of the detrimental effect of smoking by tests taken by the nurse is the important first step to begin to address giving up or reducing smoking, as one client commented 'it has made me realise that I must take some action about this – but it is hard to give up after 8 to 9 years of very heavy smoking'.

7.2 Food and Mood

In interviews and surveys offenders reflected on how the provision of fruit at approved premises and workshops had provided them with an opportunity both to try fruit that they had not been aware of and, in instances, to make fruit part of their daily intake. Nutrition remains one of the main issues affecting offender health profiles, with respondents to the Offender Health Survey recording that 21% either eat fast foods or bought ready meals daily, only 38% ate fresh fruits and vegetables daily and 14% ate fresh fruits and vegetables less than monthly.

Figure 10: The proportion of service users finding Healthy Living assistance helpful (by type of support given)



It might not be that they would achieve having 5 portions of fruit/vegetables a day, but that they would include fruit in their diet. It was also how the fruit had affected their mood as an 'extra' addition to sometimes bland diets, as cost was often perceived to make fruit unaffordable.

'More likely to now buy and eat fruit than before, not sure that it would be the full 5 portions, but at least more than before – perhaps an apple and banana.'

'The fruit is very popular generally with residents (at Approved Premises) no fruit has been left... not sure that the more fancy fruit is more popular than the usual – but some have tried different fruits.'

'I liked the choice of fruit that we had at the workshop most of the fruit I'd never heard of or seen or tasted before.'

'When I saw the grapes it made me feel happy as it is really good fruit.'

7.3 Holistic Approach

It is therefore not surprising within the sample of the Offender Health Survey (2007) that whilst the HLC has a multiplicity of effects at the individual level, as seen in Figure 10 getting general advice and help, more exercise, help with stress and depression and diet were rated the most beneficial effects of the HLC.

An holistic approach to supporting offenders with multiple needs was therefore seen as essential to foster positive cycles of inclusion and restarting of life, away from a negative loop of worsening health and re-offending.

7.4 HLC and Criminal Justice System

7.4.1 Offenders Released from Prison

For those who have been part of the prison community the HLC provides another dimension of support for clients who are newly released and have particular issues that release from prison can bring, which are not necessarily addressed by mainstream services. As seen in Sattar's (2001) work in Section 3.2 the period of release from prison can be one of the most critical times for offenders in the community. Indeed as one client reflected, without adequate help and support in areas such as drug misuse on release it becomes just one continuous cycle of drugs, offending and prison;

'Prison gets you clean – but then you are back on the street. I was put in a hostel with 11 other heroin addicts, right back in the middle of it, so it is just a case of being back in the cycle and back to jail again, the same old thing.'

The HLC was therefore seen to provide offenders recently released from prison with time to build up

confidence to re-register with a GP and gain contact with the services that they needed as the following client explained:

'Had just come out of prison so it was a nice friendly service as I wasn't ready at that point to meet people and go to a doctor's surgery and wait there. So it was good at the beginning of coming out until I was ready to go to a GPs. Had no real health issues to deal with but it was an opportunity to talk through things and sort them out if I had. Re-registered with a GP and had no problems accessing services afterwards.'

Those in approved premises who have regular visits from the nurse welcomed the flexibility that the nurse could be seen at the hostel, as one client reflected *'I class this as my 'safe place' and it helps me to see [nurse] here, rather than anywhere else'*. For issues such as mental health, drugs and alcohol misuse that may have been addressed in prison, the HLC was equally felt to be an important support not to 'go back'. As a client commented,

'Being in prison I know that a lot of people have issues such as mental health and they say that there is very little to help them - little 'out there' - when they leave prison, so good that there are things like the HLC.'

7.4.2 Offending and Health

Moreover, some offenders considered that the stigma of prison itself and being an offender had in certain aspects affected their health problems and how they were dealt with. Indeed 17% in the Offender Health Survey (2007) considered that being an offender had affected their use of health services and 42% that being an offender had affected their health. The main reasons given for this included the vicious circles that can surround offending as becoming homeless and unemployed, involved with drug abuse, the varying mental and physical effects of prison and how they became depressed and anxious as they felt 'differently treated'. A sample of respondents' comments express these factors:

'I became homeless, no money, no food'

'I'm on anti-depressants as I've been in prison and I have different moods if I don't take them I have unhappy thoughts'

'I became suicidally depressed (in prison).'

'Whilst in prison I gained 2 stone in weight'

'Doctor treated me as though I was going to mug her for drug key'

'Doctors looked differently on me during drug use'

'Treated less than human'

'It is the shame – guilt that you feel – you are now different in society'

'In prison they isolate issues too much like drugs and alcohol – they put you in boxes – don't look at the problems of addiction as a whole. You feel you are a second class citizen.'

The role of the HLC in breaking down perceived barriers to inclusion within services and that they are seen by clients as 'neutral' and not 'authority' figures is therefore vital to their role, as one client commented; *'Doctors are very much about authority and after 7 years in prison you become institutionalised and so the nurses' approach is very good'*. Moreover, that the HLC provides non-judgemental advice and support was seen as vital in any health provision; *'judging me for me and not just the offence I committed'*.

Alternatively some offenders reflected on the irony that it is within the criminal justice system as evidenced by the HLC that unrecognised needs are being addressed, to the extent that there are even instances where prison acts as a 'refuge' from drugs and personal neglect: *'I offended to go to prison sometimes to get food in me and get clean of gear.'*

'I have found that since I have been part of the Criminal Justice System I have got access to far more help and medical treatments than before – which has been very good - it almost makes you feel that you need to be part of probation again to get the treatment that you need.'

7.4.3 Cycle of Offending

Within interviews and the Offender Health Survey (2007) a significant proportion considered that their

health and propensity to offend were inextricably linked, with the redress of one dependent on the other. Drug and alcohol misuse, issues of mental health and general depression were cited as examples of unaddressed health issues that had led to offending. Indeed 20% in the Offender Health Survey stated that health had 'influenced' their offending. Furthermore, that of the 56% who reported having used illegal drugs, 50% thought that their drug use had contributed to offending mainly due to its effect on control and neglect of themselves and their need to fund their habit. The following examples are cited from open comments on the Offender Survey and interviews:

'I was a speed addict for four years so I hardly ate anything and was always awake which led to paranoia, then I was a heroin addict'

'I was very depressed and didn't know whether I was coming or going in the past when on drugs'

'Offend when on drugs, behave when I don't'

'Started offending to buy more drugs'

'I didn't care if I had the latest mobile phone or TV but I did want drugs and I was prepared to steal to get them... You have to have a motive before you do anything and my motive was to steal to get the drugs'

'Due to mental health at the time of the offence I was extremely depressed and suicidal'

'At the time of the offence and the year leading up to the offence I was very depressed and unhappy'

7.4.4 'Permanent' Role of HLC Within Probation

Most interviewees and 82% in the Offender Health Survey reflected that there was a need for probation to have a permanent form of Healthy Living Centre, that the more help they received the more 'positive' their relationship and engagement with the probation service. As a 'group' they considered there were 'so many health issues' that needed to be 'sorted out', as an interviewee commented, *'often my friends don't have a GP, one has epilepsy and collapsed several times with fitting, but doesn't have a doctor'*.

Moreover, that the more healthier they were, the more they felt equipped to 'easily' get 'back into normal life' as a client reflected *'if you don't look after yourself then you can't sort out your life and that is fundamental to coming out of prison and starting a new life'*. In respect of this 28% in the Offender Health Survey stated that their attitude to probation had changed following their visit to the HLC in respect of the following sample comments:

'Made me realise it can help me'

'To be treated as an individual and not judged'

'More relaxed about things'

'You think probation is all about being punished – but instead you get support – which is really helpful'

7.4.5 Form of HLC?

Whilst clients were more supportive of the one-to-one visits to the nurse to discuss individual health needs than attending workshops in a group situation, some did feel that there was a need for the 'choice of both'. Interviewees reflected if they had a particular problem then they would want to discuss it one-to-one as you are more likely to 'open up' than in group dynamics, but if it was a topic they were interested in and just wanted information on, like healthy eating, they would not mind attending a workshop.

There was a consensus that visits to the HLC should remain voluntary as even if you had health problems, it was still dependent on the individual to be 'ready to accept change and responsibility', otherwise *'it was just a wasting of the nurses' time'*. It was also seen as an important difference that the HLC did continue to give appointments even when a client had missed visits to the nurse, so that the chance for the more 'desperate' offenders to access services always remained open. As several interviewees recorded they had often been 'struck off' doctors and dentists for continuously failing to attend appointments when at their 'lowest'. Equally some still found GPs and formal services something that they had difficulty 'fitting' into their lives. As one client stated, *'I don't do doctors'*.

7.5 Offender Views on health – health attitudes and behaviour

The under-researched area of offender health views and perceptions was explored to understand further the individual and structural pathways and barriers within offender health inequalities.

Compared to the Salford (2005) study where health was considered to be a 'low priority' when ranged against other needs, such as accommodation, those offenders interviewed and sampled in the Offender Health Survey were virtually unanimous that health is an 'important value in their lives', with 95% ranking it as 'very important' or 'important'. When asked to rate their own perception of health in the Offender Health Survey most considered that they were in the middle of the spectrum, but 40% did state that their health was either fair (30%) or poor (10%):

Excellent	V. Good	Good	Fair	Poor
11%	16%	33%	30%	10%

Offenders' views on health, and which changes could be effected, nevertheless varied according to the stages that they considered themselves to be in within their lives and the wider lifestyle context in which change had to occur. What became apparent in the study of the HLC were the many layers of individual health beliefs and behaviour behind the statistics of offender health patterns.

7.5.1 Resource for Change

For some offenders health was the most important aspect of their life and central to their ability to cope with the problems and changes that they needed to make to get back into more settled patterns of life and 'away' from offending, as represented in the following comments:

'...When you feel healthier – you can more easily get back into normal life and deal with other problems like accommodation...'

'...Health is the most important thing – if I could get my health sorted out – I would be happy with myself and everything else would get sorted out as well...'

'...Health is the thing that keeps me going...'

'...If your diet is poor, then not much is going to change, you feel irritable – you feel argumentative and hostile – it brings out the worst in you... Nobody wants to be messed about when they are feeling rough...'

Health is therefore seen in this context not just as an end in itself but as an instrument of change. As one client explained of his visit to the HLC to seek to access a gym *'if I do more exercise I can eat better – if I eat better it will improve my lifestyle and get me back on track.'*

7.5.2 Pathways to change

Several clients equally explained that whilst they previously may have neglected their health and well being it was now a priority in their lives because of varying life factors, such as time, family commitments, death of friends or family and rapidly deteriorating health conditions that had caused them to address their health needs and lifestyles. They described how they had to get to a point where they were *'ready to change'*:

'I need to know that I will be around in 30 years time... for my children and my children's children. I look at them and want to still be here to see them...'

'I got to my 38th birthday and thought where's my life gone? It really upsets me to think how much my life has been screwed up...'

'Only now that I realise how important health is... I got into soft drugs at 18, then heroin had a really 'bad effect' on my life... I got into trouble... At 23 I decided I had to sort my life out... I am now seriously getting off the drugs and getting my life back...'

'As a lad I couldn't care less about health... my life was chaotic. I didn't have a family... my circle of friends were all a bad influence, I lived on a bad council estate and just got into drugs and everything that was bad. I have just started to realise that this is not a life...'

'Told that I would end up dead if I continued drinking...'

In the case of one offender who had had a 'real wake up call' from his GP about the effect of smoking on his arteries and had difficulties in walking this meant seeking support from the HLC to give up smoking,

'I need to change my way of life and the healthy option is there... before I abused my body'. For others it was part of a wider need to take 'control' of their lives as expressed by another client, 'I am starting to feel good about something and excited and capable and that is a new feeling. I never used to make plans... I used to live day-by-day... I have now structured my life and feel that there is something to live for...'

Pathways to changes in health and lifestyle was not, however, seen as a totally inclusive process given that health itself is as Blaxter (1990) states '*not in the minds of most people a unitary concept*'. '*It is multi-dimensional, and it quite possible to have 'good' health in one respect, but 'bad' in another*'. Hence, for some interviewees, for example, overcoming drug abuse was their main 'priority' in terms of both health and sorting out their lives, more than dealing with other health issues, such as smoking, or eating, which though important did not have such an impact on their lives and ability to function 'normally'. As one interviewee related of advice given about smoking and an improved diet,

The nurse was very helpful but I can't get myself to do it. I just keep putting it off. Tackling drugs and getting treatment is my main health problem at the moment.

Interviewees therefore reflected on how they needed to tackle 'one thing at a time', that cycles of relapse characterised attempts to 'change' particularly in issues such as drug and alcohol misuse and smoking. As one interviewee explained of his drug treatment:

'Before I got too complacent – I got clean and thought OK that's it – then I would go back to where I was – so now it is one step at a time. I think the most important thing is the 'time thing', it is now the 'right time' – I see things a lot more clearer – I have had enough...'

7.6 Barriers to change

'Social exclusion involves not only social but also economic and psychological isolation. Although people may know what affects their health, their hardship and isolation mean that it is often difficult to act on what they know.' (Saving Lives Our Healthier Nation, DoH 1999:p17)

Within interviews and surveys most offenders reported that as much as they wanted to change health behaviour it was not an easy option, with significant barriers rooted in their lifestyles, routine, coping and control strategies and perceptions and attitudes to risk and life itself.

7.6.1 Offender Health Survey

In the Offender Health Survey respondents therefore reflected on a variety of inter-related structural and behavioural barriers to changing lifestyles when asked 'is there anything that stops you from improving your health?'

Cost	48%
Lack of motivation	30%
Transport	18%
Would mean giving up something you enjoy	17%
Access / choice of services	15%
Poor housing, i.e. lack of heating	13%
Influence / needs of family / friends	12%
Lack of home appliances (e.g. cooker / fridge)	9%

As seen cost was the main factor given and this was qualified in open comments particularly in relation to gym membership as '*money for gyms*', and '*cost of gyms*'. Indeed, in a further question on physical activity 40% commented that they would like to do more physical activity with the joining a gym and gaining if possible free access to one a prime motivation. Some mentioned this specifically in relation to the HLC - '*joined the gym and I have achieved that with Healthy Living*'.

Others commented on very difficult circumstances where they were '*Homeless – eating out of skips*' – '*living in a car park*' barriers to change that were reflected in the 13% who stated that they had poor

housing and 9% the lack of home appliances. Equally 30% did consider their lack of motivation which could be affected by physical barriers as much lifestyles. Moreover 17% related that barriers included 'giving up something that was enjoyable'.

7.7 Emergent Themes

Within interviews the structural and individual barriers to adopting healthier lifestyles were further explored and the resulting and interwoven themes emerged from the qualitative data.

7.7.1 Low Self Esteem

For some interviewees who had low self-esteem and little 'value' in living, 'taking care of themselves' was not central to their lives, as demonstrated in the following comments:

'I have very low self-esteem and don't care about myself...'

'I don't care about being healthy... I want to die and don't know why people help to keep me alive...'

'Been neglecting myself for a long time... I could be a lot healthier...'

For those offenders who had particularly difficult living circumstances such as one who had lived in a car for a year it was not surprising that 'just being in a house' had a positive effect on their ability to change and their self esteem.

7.7.2 Routine, Coping and Control Strategies

Interviewees therefore gave reasons for 'unhealthy' behaviour, such as smoking and taking drugs, which were rooted in their lifestyle and often provide means of comfort, coping, pleasure and stress release in difficult lives. Indeed, smoking, alcohol and drug misuse were often described as 'crutches' to get them through the day and difficult periods of their life:

'Smoking is my safety pillow...'

'I want to stop smoking but I like smoking and I haven't yet got the willpower to give up...'

'When you have a fag it releases stress from you...'

'Puff on a cigarette and everything seems much better... it is just something that I do... something in your system...'

'Mostly you take drugs/smoke to deal with the stresses of life...'

'Smoking helps me to cope in stressful situations... as I am not settled and have very stressful factors in my life... it helps a lot...'

'I want to give up smoking – but it's a habit – something to turn to – you use it as a crutch – it is an addiction. The alcohol is also a crutch...'

As seen in Section 7.5.2 health patterns are not in a silo but inter-related, so that changes in one part of a health profile may be counter-balanced by the effect in another. Interviewees therefore explained how drinking and smoking may provide a substitute for other health behaviours, such as drugs, as there was a need to ensure that there was another means of comfort/coping, with an often unconscious 'weighing' of gains against 'sacrifices' if change was to be effected.

'If I gave up smoking I would get bored and start taking drugs instead... it relaxes me from the stress of the family and everyone else...'

'I have sacrificed a lot of things coming off drugs...'

'I'm getting off drugs, but here is now the problem of drinking 24/7 which fills me up instead of food.'

7.7.3 Risk

Offenders equally expressed multiple attitudes to risk taking behaviour that related to individual life circumstances and justifying and rationalising behaviour within the context of 'official' health messages.

7.7.4 Assessing Risk

As interviewees explained at various 'low points' in their life, particularly when on drugs, they were unable to take control and fully consider the health risks that threatened them:

'I didn't eat right...or do anything right, I used to live on a Weetabix a day (when on drugs). It never enters your head to eat properly... be bothered about health...'

'I have shared needles and put myself at risk... you do think about the risk for one second and then the next second you think about the fix...'

'You know about things like Hep C... but you justify it to yourself. You know the rules... but you put it to the back of you mind and get the fix and say I'll worry about that next time... You say 'I shouldn't have done that, but then it goes out of your mind...'

'You have no choice (for health) when you are on drugs...'

Others stated that it was the risk itself that they were 'chasing', or were oblivious to, whether in relation to drugs, offending or other aspects of their health lifestyle. Given that offending itself is dependent upon acceptance of risk; that health is another element subject to uncertainty and offenders' lifestyles are often dependent on thinking about how to survive today, rather than planning for what appears an uncertain future, short-term benefits are perceived to outweigh unknown long-term costs.

'(It's) the risk that you are chasing...'

'I am not really worried about the length of my life... I live for the moment. Something I don't think about is risk...'

'I take one day as it comes... who thinks about what is around the corner?'

'Could die tomorrow in an accident... so why bother worrying about something like smoking?'

'You might get a flash when you see something like 'smoking kills'... but then later you pick up a fag...'

'When you're time's up, your time's up and that's all there is to it...'

7.8 Attitude to Health Messages

For some interviewees the constant warnings about general health risks, such as smoking, through the media sometimes had a detrimental effect as they considered that they were being constantly 'bombarded', 'it's all do this and do that and you feel sod em'. Moreover, there was a consideration that the more the risk was emphasised the more they were aware of the exceptions to the health messages and the less they consequently 'trusted' them, as a interviewee commented, 'my grandma had 40/50 woodbines a day and still lived to her 80s, so you think why bother?' This particularly underlies the epidemiological/population or prevention paradox as outlined in the Wanless Report (2004):

'...That which is true at a population level (such as the smoker having an increased chance of dying from certain diseases) is not true for every individual (not every smoker will die from smoking-related disease). This influences the perception of risk by the public, to whom the obese individual who lives until age 100 or the evidently fit non-smoker who dies at 30 are seen as validation of unhealthy behaviours, when in fact such occurrences are outliers and outside normal expectations...'

7.9 Choice and Control

In open comments on the survey and within interviews the overall perception amongst offenders remains that health and its attendant risks remain 'down to the individual' and their responsibility and control:

'If you break a leg – it is something the Doctors can sort – but smoking – you are the one who has to do it...'

(Health is) – '...down to the individual... you can't get a gun to his head to stop...'

(Smoking is) – '...matter of individual choice at the end of the day...'

'Getting off drugs...really down to yourself...'

7.10 Overview

As much as offenders are aware of the health messages, within their lifestyles and perceptions changing health profiles is often not an easy option. In this respect the work of the HLC is particularly valuable in providing *'an infrastructure that is able to reach out to people in particularly difficult circumstances and provide them with relevant practical support'* (Choosing Health 2004:p105). Indeed, despite recognising barriers to 'healthy choices' many interviewees did consider that whilst they may not be 'ready for change' at the present time, overall the HLC could personalise the health message for them and provide them with the information and support that they required at the individual level, which they could reflect on and act on both now and in the future.

Summary and recommendations

Whilst much literature and policy exists concerning the nature and redress of health inequalities and re-offending, significant gaps remain in understanding and service delivery. Within the offending community emphasis and knowledge centres mainly on quantitative statistics and those offenders in custody, rather than in the community. Lincolnshire Probation's HLC therefore provided an exceptional opportunity to research at a micro level the structural and individual interaction between offender health profiles and alternative models of 'health' care and advice. The main issues to be raised in the five years of the project are explored below:

8.1 Healthy Living Model

As a 'platform of innovation' the HLC has had the challenge of a blank canvas in which to develop and sustain an innovative service rooted at local levels of community need. As in the case of other Healthy Living Centres reported in national evaluations by the Bridge Consortium (2005/2007) and Platt et al (2005) it has had to operate with an ever-changing landscape in terms of personnel, partnerships and organisational structures. In continuously developing 'good practice' it had to learn and understand what was impractical as much as 'what works'.

The gradual set up of structures, processes and ethos of the HLC has nevertheless provided strong foundations in which change and sustainability could be effected. Indeed, one of the interesting themes to emerge from the interview and survey data was the unity of views from all the stakeholders that a distinctive model of care had been created within the HLC particularly in relation to 'service accessibility' and 'service appropriateness'.

Flexibility of provision has been especially valued, with the changing of the usual health model of the user having the onus to seek help and information, by the HLC alternatively bringing the service to the offender. That nurses can be seen on probation premises at the offender's convenience has had an impact on making offenders comfortable about accessing services, including those who have been recently released from prison and in approved premises, where continuity of care is an important factor.

The added value of the service in terms of the time that can be given to a client's appointment and the ability to build up rapport and trust with the nurse was often contrasted with the time limits on a usual GP or mainstream health appointment, where it was difficult to talk through a range of health concerns. The personalising of the service with the emphasis on listening to what the offender considers are his/her needs in a holistic rather than silo view, was equally seen as central to supporting change. Service appropriateness and accessibility was therefore most about being a service led by individual client need, rather than trying to fit the client around the service. As a service there is much that mainstream services can learn about how to approach and engage those most vulnerable in society and who most need support.

8.2 Role within Probation

The HLC has, over the five years of the project, become integral to the probation service. Indeed it was probation staff that identified in the bid that the role of the probation service in providing a gateway to health services and support was essential for a large number of their clients who were continually falling through the gaps of mainstream provision and had health concerns that were more greatly represented in the client group than the general population.

A HLC within probation has therefore filled a resource gap for both probation and offenders by providing not only the tools of identifying more comprehensive health needs through screening than that presently provided by OASys, but a service that they can easily refer to for advice, advocacy and access for their clients. This had provided offender managers with the confidence to deal with health concerns that previously may not have been recognised or not dealt with either because of pressure of time or uncertainty of how to help, or which services to access. 'Common' health issues amongst offenders, such as self-harm, risk of HIV and unresolved grief could now be addressed and recognised by probation staff.

The value of the HLC is equally placed in relation to its ability to act as part of a 'multi-modal' approach to enable compliance with the probation order and

ultimately reduce re-offending. Given that the OASys system has highlighted that offenders have a wide range of criminogenic needs, on average four per offender; multiple approaches to offender need have been cited as *'likely to be the most effective way of treating offenders'* (McGuire 2002). It is no one factor that causes the propensity to crime such as homelessness, unemployment, mental health problems, nor any single intervention that can ensure resettlement, but rather a range of interventions that tackle these complex inter-related issues that can break down the revolving door and 'vicious circles' that surround most recidivism.

As part of a 'multi-modal' approach the HLC was seen not only to deal with already acknowledged criminogenic needs, such as alcohol and drug misuse, but also to begin to identify and deal with the wider health issues that also prevent successful completion of the probation order; inclusion and reduction of re-offending. Problems such as sleeping, not eating regular meals, low self-esteem and a general neglect of health were all seen to have an impact on the effectiveness of the probation order and the ability and motivation of the offender to 'sort out' his or her life.

8.3 Offender Health Profiles

The study of the HLC has therefore begun to unpick the complexity that underlies the wide views and issues behind the statistics of offender health profiles and illustrated a broader approach to the more usual 'definitions' of offender health needs.

Statistics from case progress information collected in the HLC's fifth year has shown that the issues around offender health are much wider than the commonly-stated prevalence of substance misuse and mental health problems. NHS dentist registration and diet/healthy eating are by far the most commonly discussed concerns with over half of all service users discussing these issues with the nurses. Sexual health, smoking cessation and exercise/gym were also very common, with approximately a quarter of all service users being given advice on these subjects. The proportion of offenders following the advice or referrals varies greatly between health topics with the majority taking up advice on GP registration and following referrals to go to the GP but relatively few

following advice on smoking cessation, possibly for the reasons discussed in Section 7.7 above.

The research has equally opened up further understanding of the nature of structural and individual barriers to changing offender health profiles. Whilst most offenders recognised that health is an 'important value' in their lives they equally reported on the inter-related structural and behavioural barriers to change rooted in their lifestyles, routine, coping and control strategies, attitudes to risk and life itself. Drugs, smoking and alcoholism were often symptoms of underlying problems providing means of 'coping' in often difficult lives.

Pathways to change are therefore not necessarily a linear process dependent on the motivation and ability of the offender to change at a particular point in time. Rather than 'bombarding' the offender with general health messages, the HLC could provide the information and support that an offender required at the individual level which may be acted on at whatever level they felt comfortable with.

Offenders have reported the already established link in the literature between health and offending with the redress of one dependent on the other. Moreover that being an offender itself, the effects of prison and the stigma that can be attached and the vicious circles of homelessness and unemployment that may result had compounded in instances to affect their health and access to services.

Alternatively it is recognised by offenders that it is within the criminal justice system with initiatives such as the HLC that health needs are being both recognised and dealt with. The challenge for the future as related by Lord Hunt (2008) is for more partnership between health and criminal justice systems to break down the inequities that exist in offender health profiles so that help is sought and received before the 'crisis' has occurred:

There is a connection between health inequalities and re-offending... The Criminal Justice System can act as a gateway to health services for a part of the population that finds it hard to access appropriate mainstream health and social care services. It can present a particular opportunity to make a significant

contribution to the health and well-being of an excluded proportion of our society.

Too often, these people have not previously engaged with health or social services and only access the services they need when their situations have led them to a crisis point. This is often far too late for any significant preventative health intervention to occur or to help prevent family breakdown. It must be cheaper and more effective for health and social services to intervene earlier, to improve and promote the health of vulnerable people whose situations might lead them to offend.'

8.4 Recommendations

The work of the Healthy Living Centre has shown that it is imperative that services for offenders take a broad and holistic view of health and do not focus solely on the perceived primary needs of substance misuse and mental ill-health. Consultation with offenders is vital in order to ascertain what they perceive their needs to be as, in order to engage offenders and have the desired impact, any service must not only meet theoretically identified needs but also the perceived needs of the people who must want to use the service.

The service must be trusted by both offenders and offender managers alike. For offenders, this can be developed by ensuring it is a voluntary service and is not seen as part of their punishment, which also avoids tokenistic attendance by those who have no motivation or intention to follow the advice or referrals. The service must also be bound by normal medical confidentiality, with the offender understanding how and when their information may be shared. Perhaps most importantly, trust can be developed by encouraging healthy decisions instead of dictating what must be done and by providing appointments of sufficient length to allow trust to develop between the offender and the healthcare worker. This time to discuss concerns and get to the root of problems in an unhurried environment is highlighted as one of the most beneficial aspects of the Healthy Living Centre.

Brief health screening, carried out by Offender Managers at the earliest opportunity, ideally at Pre-

Sentence Report or at the initial appointment post-sentence, provides an opportunity for Offender Managers to build health into the package of services that meet the needs of each individual. The health section of OASys is lacking detail and could be expanded to include a brief health screening tool, thereby also improving the flow of some basic health information between prisons and probation services. This could be further enhanced by improved joint working between prison healthcare and probation health teams in preparing for release and providing continuity in care, ongoing support and motivation, which may subsequently help to reduce the risk of suicide and self-harm in the first few weeks after release.

The Offender Managers who complete the health screening must be given the knowledge, understanding and resources such that they can act upon their initial findings. As a minimum (and with appropriate training) this could involve Offender Managers making referrals directly to mainstream services, however the Healthy Living Centre has identified that there are distinct benefits in having someone recognised within health and social care communities but also geographically placed to liaise with Offender Managers. The facility to liaise with a healthcare specialist on site and to refer to someone who has the knowledge and expertise to assess, advise, signpost and refer offenders with potentially complex health needs is now recognised by almost all Offender Managers as an invaluable additional resource.

It must be recognised that many of the headline priorities for the NHS and criminal justice services will not be met quickly and directly through a service such as the HLC. It is therefore vital that intermediate outcomes which do, in turn, impact on re-offending, coronary heart disease, stroke, diabetes, etc. are given due weight. While some outputs are more easily measured, such as the number of offenders registered with a GP and the proportion who smoke, it is also important to take an holistic view and recognise that health and well-being are, in many ways, subjective. Some form of self-assessment, such as the use of Rickert's scale, is therefore highly valuable and provides an individual's balanced view of their health rather than solely measuring each aspect in isolation.

Equally, it is important to recognise that a service such as the Healthy Living Centre's can have an impact on self-esteem and self-confidence which, although not often considered in terms of health, can have a significant positive impact on employability, social exclusion and, potentially, re-offending.

Encouraging GP registration and facilitating this when necessary should be a vital part of any service as it forms the basic link to mainstream healthcare in the community. Offenders should also be given the knowledge and understanding of how to register and where to go for information or assistance so that the work is sustainable and the individual and their family know how to maintain contact with services should they move. However, despite the importance of ensuring the link to mainstream services is made, it is important that a health service specifically for those on probation is based alongside probation staff and that appointments can be arranged as close to supervision appointments as possible in order to make the service as accessible as possible. Health promotion activities, key to raising health awareness, were also found to work best when run for a pre-formed group (e.g. at an UPW session or after an accredited programme) or as a drop-in format in reception areas, instead of expecting offenders to attend for an additional appointment.

In a more general sense, it is important for mainstream health staff to have an awareness of how to deal with people who may, for example, find it hard to express themselves or may have literacy problems or do not fit with the socially acceptable 'norm'. Awareness training built into inductions and initial training may give staff the tools to know how to better meet the individual needs of all patients, not just those who are socially excluded. Similarly, criminal justice staff need a basic awareness of the healthcare pathways, processes and applicable services. This could be built in to initial core training for prison, probation and probation service officers.

In summary, any service which takes healthcare and health promotion to offenders and provides the time and holistic approach to meet their potentially complex needs can be a valuable addition for offenders and for the criminal justice and health services. Assisting offenders in overcoming their

personal barriers to accessing appropriate mainstream provision and recognising the accomplishment of seemingly small, intermediate goals can impact on areas much wider than health and well-being.

8.5 The Future of the Healthy Living Centre

The Healthy Living Centre has been in a position that is unique among the Big Lottery funded Healthy Living Centres. As other centres have reached the end of their funding and have been struggling to attract the necessary income to continue their work, Lincolnshire Probation's Healthy Living Centre has been at the centre of a rise in recognition that the health needs of offenders spans beyond those in custody, and that improving health and access to mainstream healthcare plays an important part in reducing re-offending. With this focus, the drive to reduce health inequalities and the evidence of need produced by the Healthy Living Centre, it was able to demonstrate that it is meeting a considerable number of priorities for both the National Probation Service (Lincolnshire) and Lincolnshire teaching Primary Care Trust. The Project was awarded recurrent funding from LtPCT to continue the services it has established and to expand to provide services to The Nomad Trust hostel in Lincoln and the direct access centre for the homeless which is planned for the south of the county. The Project will also increase the skills mix of its staff and, along with several other probation areas, is hoping to take on Health Trainers to further its work in helping offenders make healthier lifestyle choices.

With the national Offender Health and Social Care Strategy likely to be published in Spring 2009, it is hoped that the work of Lincolnshire Probation's Healthy Living Centre will be used as a basis on which other areas can develop similar services to meet the needs of their offenders. The Healthy Living Centre will, during this time, continue to develop and strive to find innovative new ways to engage those who are hardest to reach.

Appendix

Appendix – Health Inequalities Impact Assessment

This summary details the impact of funding cessation for the Healthy Living Centre, NPS Lincolnshire. For each health determinant, the populations affected are identified and, for each of those, the size of the health impact (between +++ and - - -), the opportunities/risks and the impact on other services or partners is explored.

Health determinant: Biological Factors

Population(s) affected: Service users

Health Impact Size: - - (in general); - - - (for some individuals)

Opportunities/Risks:

- No decrease in blood pressure;
- No decrease in weight;
- No decrease in alcohol consumption;
- Failure to improve diet;
- Less exercise taken;
- Failure to improve health;
- Worsening of mental health issues;
- Increased risk to self and others;
- Less identification of mental health problems and improvement in mental health;
- Increased health risks;
- Failure of health services to pick up excluded individuals;
- Failure to empower individuals to educate family/friends;
- Less opportunity to create new social networks e.g. through gym attendance;
- Increased morbidity and mortality;
- Less knowledge of the necessity for self-examination and health screening;
- Less knowledge of own status regarding blood-borne diseases (potential impact on family, friends & general population due to increased prevalence);
- Less understanding of how to reduce the risk of blood-borne diseases;
- Less knowledge of safe sex practices, including risks of sexually transmitted diseases and more transmission of diseases;
- Less chance for discussion and identification of hereditary problems e.g. breast/bowel cancer and heart disease (not lifestyle induced);
- Continued high prevalence of smoking - fewer referrals to Phoenix smoking cessation service and fewer offenders progressing through cycle of change regarding smoking habits;
- Failure to improve dental health of offenders – continuing poor dental hygiene leading to pain, abscesses, potential for septicaemia, need for emergency treatment and increased GP and A&E attendance.

Impact on other services or partners:

- Decrease/failure to increase GP workload in short-term but increase in workload due to later presentation of disease/conditions;
- Housing services – failure to stabilise some individuals (especially in terms of drug/alcohol use);
- Criminal justice services, courts etc – no change in re-offending linked to health intervention;
- Secondary health services and A&E – increase in costs due to later intervention;
- Health services in general – increased costs due to failure to participate in healthier lifestyle activities e.g. exercise, diet, etc.

- Phoenix smoking cessation service – decrease in knowledge of service available and referral numbers.

Population(s) affected: Families and partners

Health Impact Size: - - (in general); - - - (for some individuals)

Opportunities/Risks:

- Status regarding blood-borne diseases not known – potential for increased risk of transmission;
- Greater risk of sexually transmitted diseases and unplanned pregnancy with associated increase in morbidity and mortality;
- Failure to improve diet of co-habitants and/or dependents;
- Potential for increased risk of violence towards, and low mood of family if offender's mental health needs not addressed;
- Less improvement in family stability;
- Less improvement in family financial situation.

Population(s) affected: General population

Health Impact Size: -

Opportunities/Risk:

- More unplanned pregnancies with associated increase in morbidity and mortality;
- Failure to decrease prevalence of blood-borne and sexually transmitted diseases;
- Failure to impact on re-offending.

Health determinant: Personal/ Family Circumstances & Lifestyle; Social Environment

Population(s) affected: Service users

Health Impact Size: - - -

Opportunities/Risk:

- Health problems not identified as early/at all;
- Worsened physical & mental health;
- Worsened confidence & self esteem;
- Decreased contribution to society;
- Weakened relationships with family, friends and partners;
- Increase in re-offending;
- Worsened financial situation, therefore unable to meet financial responsibilities (i.e. rent, bills, etc.);
- Less likely to find and/or keep employment;
- Decreased understanding of safe sex practices therefore increased risk of sexually transmitted diseases and unplanned pregnancy;
- Not accessing healthcare services early enough or at all;
- Less/no re-enforcement of lessons learnt in Low Intensity Alcohol Modules programme and less continued motivational work to reduce drug/alcohol misuse.

Impact on other services or partners:

- More reliance on secondary and emergency healthcare services as less early intervention;
- Housing (councils, housing associations and private landlords) – increased risk of having to deal with rent arrears due to poorer financial planning;



- Utilities companies, councils, credit companies etc. – increased risk of customers failing to pay bills in full and on time;
- Increased burden on maternity services associated with increase in unplanned pregnancies;
- Employers – smaller pool of workers from which to fill vacancies as some people unable to work due to ill health or substance misuse issues;
- Central government – increased numbers of benefits claimants.

Population(s) affected: Families and carers

Health Impact Size: - - -

Opportunities/Risk:

- Less support to stay together;
- Poorer relationships;
- Less appreciated;
- Accommodation;
- Family planning, STDs, contraceptives;
- Less referrals and knowledge of other agencies that can offer assistance e.g. Surestart;
- Less sense of belonging;
- Risk assessment;
- Less information on public health issues passed on.

Population(s) affected: Society

Health Impact Size: - -

Opportunities/Risk:

- Increase in re-offending;
- Others' attitudes;

- Benefit agencies, police, courts, healthcare, probation, doctors (pre-warning), neighbours, local community, councils, employers (less productive and smaller choice of employees);
- Loss of skilled workforce due to inability to work.

Population(s) affected: Friends

Health Impact Size: - -

Opportunities/Risk:

- As for family, plus...
- Less belonging and support;
- Less likely to keep a network of friends if physically and/or mentally unwell;
- Less likely to contribute positively in society (e.g. football or any sports).

Health determinant: Public Services

Population(s) affected: Probation Service

Health Impact Size: - -

Opportunities/Risk:

- Decreased quality of risk assessments as fewer agencies involved;
- Reliant on Offender Managers (OMs) to address problems – don't necessarily have time and knowledge;
- No central, updated directory of services;
- Less compliance by some offenders and increased re-offending by some;
- Less time for OMs to address general re-offending issues.

Population(s) affected: GP services

Health Impact Size: - -

Opportunities/Risk:

- No summary of need given to GPs;
- More difficult presentations;
- Service users not as confident to ask questions and less effective at communicating problem, resulting in longer and more frequent consultations;
- Less early intervention, therefore more urgent cases.
- Less mental health promotion to prevent escalation

Impact on other services or partners:

- More emergencies
- More likely to end up at A&E;

- More likely to require secondary care due to late presentation of problem.

- Less access to primary care

- Less preventive care

Population(s) affected: A&E

Health Impact Size: - -

Opportunities/Risk:

- Less appropriate use of resource – wrong time and medical conditions;
- Increased risks due to inappropriate behaviour and chaotic presentations;
- Higher costs due to more inappropriate presentations.

Population(s) affected: Accommodation Services

Health Impact Size: -

Opportunities/Risk:

- Less stable mental health cases unable to access service.

Population(s) affected: Dentistry

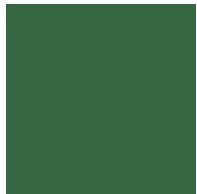
Health Impact Size: -

Opportunities/Risk:

- Fewer registrations and preventative care;
- More emergency work;
- More DIY dentistry and self-medication;
- More presentations with poorer dental health, therefore less profit.

Impact on other services or partners:

- More presentations at Dental Access Centres;



- Potential for increased A&E presentations;
- Potential for increased drug misuse and impact on drug services.

Population(s) affected: Police

Health Impact Size: -

Opportunities/Risk:

- More alcohol-related crime and disorder.

Impact on other services or partners:

- Knock-on impact on probation and prison services.

Health determinant: Public Policy

Population(s) affected: Offender Health

Health Impact Size: - -

Opportunities/Risk:

- Less information on non-prison offender healthcare access.

Impact on other services or partners:


- Less evidence on which to base future strategy policy.



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