Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Gwasanaeth Carchardai a Phrawf EM yng Nghymru

HM Prison & Probation Service in Wales

A Health and Social Care Needs Assessment for Residents in Approved Premises in Wales

2023

Matthew York

Specialty Registrar in Public Health, Betsi Cadwaladr University Health Board

Title
A Health and Social Care Needs Assessment for Residents in Approved Premises in Wales
Authorship
Written by Matthew York, Specialty Registrar in Public Health, Betsi Cadwaladr University Health Board. Produced in partnership with HMPPS
Publication date
September 2023

Acknowledgements

This Health and Social Care Needs Assessment would not have been possible without the hard work of many colleagues. In particular, I would like to offer my thanks to:
All the residents and staff of the Approved Premises
Members of the Health and Social Care Needs Assessment Working Group
Colleagues within HMPPS, especially Peter Salami and Bethan Waites
External stakeholders
Colleagues within BCUHB Public Health Team
BCUHB Welsh Language Translation Team
Ceriann Tunnah, Consultant in Public Health, BCUHB Public Health Team

Glossary

Acronym	Definition
AP	Approved Premises
BCUHB	Betsi Cadwaladr University Health Board
CAS	Community Accommodation Service
CJS	Criminal Justice System
HSCNA	Health and Social Care Needs Assessment
HMPPS	His Majesty's Prison and Probation Service
MAPPA	Multi-Agency Public Protection Arrangements
PSO	Probation Services Officer
RSW	Residential Support Worker

Contents

Index of Figures

Index of Tables

Executive Summary

The health needs of the prison population are well documented, but less is known about the health of those under the supervision of the probation service, and there has been very little research into the health and wellbeing needs of residents in approved premises (AP). This Health and Social Care Needs Assessment (HSCNA) is the first systematic analysis of the health and social care needs of AP residents in the United Kingdom. This needs assessment was conducted alongside a Workplace Wellbeing Needs Assessment for AP staff and the findings from both will be used to inform the development of a Health and Wellbeing Strategy for APs in Wales.

Previous research into the health of those within the criminal justice system has demonstrated a higher prevalence of physical and mental health conditions than the general population and a higher level of substance misuse. Health status has been linked to reoffending, so being able to adequately identify and treat health conditions offers benefits to the community in addition to the individual.

A mixed-method strategy was employed to understand the demographics and health and social care needs of the AP resident population in Wales. It utilised surveys, focus groups, and interviews for the residents; interviews for staff members; and a survey and interviews for wider stakeholders. Current service provision was mapped, and a gap analysis was undertaken to highlight areas of unmet need.

Questionnaires were completed by 53 residents which represented 70% of the AP population in Wales. Physical health conditions were reported at rates equivalent to, or lower than that seen in the general population. The main unmet physical health need related to dental disease. In contrast, the rates of mental health conditions, learning disability, and neurodiversity were substantially higher than in the wider community. There was a large unmet need for mental health services, in particular gaining access to community or secondary care services during the limited stay within the AP, and ensuring a continued supply of psychoactive medications between release from prison and re-establishing a supply within the community.

The transitions between prison and AP, and AP and the community caused considerable anxiety for many residents, as well as the potential disruption to mental health treatment programmes. Whilst any change has the potential to upset the status quo, there are occasions when the system serves to exacerbate rather than solve this disruption. Some of those system issues are outside the control of HMPPS whilst others present opportunities to improve services provided in collaboration with partners, in particular the Local Health Board, especially with regard to medicines management and access to mental health services.

Difficulties in finding available housing is the biggest social issue and causes considerable additional anxiety amongst residents and is sometimes the reason for the duration of stay in the AP to be extended. Seventy-five percent of residents did not know where they would be living on release from the AP. This is likely to be due to a combination of the limited availability of social or private housing, and because in a market where demand outstrips supply, former offenders often find themselves towards the bottom of the queue. On rare occasions, residents are released to no fixed abode to become street homeless. Whilst it is outside the gift of HMPPS to directly influence the availability of housing, this does present opportunities for further collaboration with local authorities and third sector organisations to conduct more research into this issue to search for potential solutions.

All APs have close connections with local services within the public and third sectors in areas such as health, substance misuse, social care, rehabilitation, and recreation. These relationships have come about primarily through the hard work and local knowledge of AP managers although this has become easier due to the highly regarded contributions of the recently appointed Partnership and Stakeholder

Lead for Approved Premises. There is an opportunity, in partnership with external agencies, to investigate the possibility of producing a blueprint of required services for all AP residents and thereby providing a universal offer throughout Wales.

APs are staffed by a very knowledgeable and committed cohort of HMPPS staff. However, little extra capacity exists in AP staffing levels such that any disruption due to sickness or annual leave potentially leads to the prioritisation of supervision duties at the expense of rehabilitative work. This has the dual effect of reducing the ability to provide meaningful rehabilitative interventions as well as having a knock-on effect on staff wellbeing with many feeling that the current staffing levels are unsafe.

In summary, AP residents in general feel that APs are a supportive environment, and that AP staff are doing everything they can to cater for their needs. Frustrations are generally aimed at the wider health and social care system. A number of areas could benefit from additional research or review, in particular with respect to the transition from prison to AP and AP to community, the provision of medicines within the AP, access to mental health services, access to dental care, the implementation of a universal offer of services to AP residents throughout Wales, and staffing levels.

Chapter 1 – Introduction

This Health and Social Care Needs Assessment (HSCNA) was requested by His Majesty's Prison and Probation Service (HMPPS) to gain a better understanding of the health and social care needs of residents in Approved Premises (APs) in Wales. The project ran alongside a Workplace Wellbeing Needs Assessment for HMPPS staff who work in those APs and the results from both will inform the development of the first Health and Social Care Strategy for Approved Premises in Wales.

Approved Premises (AP) are hostel type premises used for the temporary accommodation and supervision of people who, on release from prison, are considered to pose a high to very high risk to the public. The aim of the AP is to mitigate the risk by testing compliance with licence conditions prior to release into the wider community. Research suggests that this population is likely to have a higher level of health and social care needs than the general population and that there is an association between the level of unmet health needs and the rate of reoffending.

Throughout England and Wales there are approximately 100 APs, with four being situated in Wales. The Welsh APs accommodate approximately 100 male residents at any one time. There is no current AP provision within Wales for women. Residents typically stay for between eight to twelve weeks before moving on to accommodation within the community. The time in the AP affords a final opportunity to address health and social care issues for this high-risk cohort prior to release from detention within the criminal justice system.

A Health and Social Care Needs Assessment (HSCNA) is a systematic way to describe the health and social care needs of a defined population, to examine the services provided to address those needs, to identify any gaps in service provision, and to make recommendations to address any unmet needs.

Little previous research has looked at the health and social care needs of people on probation, and research into the needs of AP residents is lacking. Data from the prison population demonstrates a higher prevalence of a range of health conditions when compared to the general population, in particular mental health, learning disability, and substance misuse. This HSCNA represents the first systematic study in the UK into the health and social needs of AP residents.

Chapter 2 - Background information

The Criminal Justice System

The latest figures show that there are 84,372 people in prison in England and Wales, and 240,431 on probation (Ministry of Justice, 2023). The organisation tasked with carrying out both custodial and community sentences, as well as probation and rehabilitation, is His Majesty's Prison and Probation Service (HMPPS). Approximately six months prior to the end of their time in prison, offenders will be allocated a probation officer (PO) who, after conducting a risk assessment, will decide on the terms for release into the community. The stipulations applied are commonly referred to as the 'licence'. For those deemed to represent the highest risk to the public, a period in an AP may be recommended. The decision-making process for those in the highest risk categories may additionally be subject to a process of risk assessment and management known as Multi-Agency Public Protection Arrangements (MAPPA) where agencies such as the police, HMPPS, local authorities, housing providers, and lay advisors discuss information about individuals to assess the risk posed to the public and formulate a risk management plan. The plan is bespoke for each offender, and stipulates conditions attached to their release into the community. The vast majority of those in an AP will have MAPPA in place. If the terms of the licence are broken, offenders can be returned immediately to prison.

Probation Services

Probation is the term given to court-imposed sentences which are being served outside a prison – this may be a sentence served wholly within the community or may be the balance of a custodial sentence served on licence. Supervision of those on probation is carried out by the National Probation Service, an executive agency of HMPPS. Approximately 28,000 staff are currently employed in the Probation Services in England and Wales and that figure is due to increase. The aims of probation are to reduce reoffending, support the victims of crime, keep the public safe and to help offenders make positive changes to their lives through the provision of a variety of resettlement and rehabilitation programmes (Probation Service, 2022). The Probation Service is currently going through a period of reform as laid out in their Target Operating Model (HMPPS, 2021).

The National Probation Service Health and Social Care Strategy 2019-2022 identified the following priority areas for those on probation: learning disabilities and challenges and autism; social care; physical health; the offender personality disorder pathway; substance misuse; suicide prevention; and mental health and wellbeing (Figure 1) (National Probation Service, 2019).

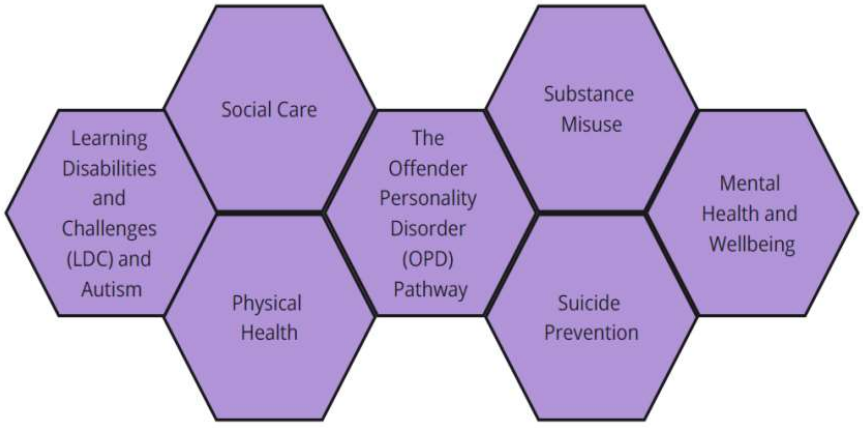

Figure 1 - the priority areas of the National Probation Service Health and Social Care Strategy 2019-2022 (National Probation Service, 2019)

What are Approved Premises?

Approved Premises (APs) (formerly known as Probation or Bail-Hostels) are hostel-type accommodation which have been approved under section 13 of the Offender Management Act 2007 (Offender Management Act, 2007) for the temporary supervision and rehabilitation of offenders and for people on bail (DHSC, 2022). They are staffed 24 hours per day and accommodate high-risk offenders, the majority of whom come straight from prison. There are 101 APs in England and Wales providing accommodation for approximately 2,267 offenders at any time (HM Inspectorate of Probation, 2017). There are plans for additional APs, especially for those which cater for women (HMPPS, 2021). Wales has four APs with approximately 100 residents. They are located in Bangor, Wrexham, Cardiff, and Swansea (Figure 2). The APs in Wales house only men, 60% of whom have been convicted of sexual offences and the remainder violent or other offences. Female offenders from Wales who need the services of an AP must go to one of the small number that exist in England.

The aims of APs are to support the safe transition from custody into the community and to provide high-level monitoring and public protection. APs aim to balance control of the risk to the public with the duty to care for the residents (HMPPS, 2021). HMPPS identifies the core tasks of APs to be risk management; purposeful activity; security and substance testing; curfews and other licence conditions; compliance; resettlement; and addressing health, mobility and social care (HM Inspectorate of Probation, 2017).

Figure 2 - location of approved premises in Wales

What happens in APs?

The typical stay in an AP lasts between eight and twelve weeks but can be longer in some circumstances. The residents are subject to enhanced monitoring and supervision with a focus on risk management, victim protection, rehabilitation, and reintegration into the community. General restrictions imposed on residents include the observance of a curfew and abstaining from alcohol and drugs, but there may be additional stipulations such as the need to sign in at prescribed times. This gives a window of opportunity to identify high-risk offenders who are unable to comply with licence conditions so that such individuals can be returned to prison.

The residents of APs often have complex health and social care needs and the time in the AP affords an opportunity for each resident to be signposted to agencies that are able to offer support, for example GPs, substance misuse services, community mental health teams, and social workers.

APs are staffed by one manager per site, several residential support workers (RSWs), several probation services officers (PSOs), and auxiliary staff. RSWs work twelve-hour day or night shifts to maintain 24-hour cover within the AP and to staff the front desk where residents sign in and out in accordance with licence conditions, and to offer support to AP residents. PSOs undertake offender management tasks which contribute to the delivery of the offender management plan, and work with other agencies to best meet the needs of residents. PSOs are able to undertake the duties of the RSW when required.

AP residents are frequently subject to multiple vulnerabilities. The period of residence within an AP is state-sanctioned rather than being voluntary, therefore it could be argued that the state holds a higher duty of care to ensure residents' wellbeing than it does for the average citizen in the community.

Offender health

Despite many more people being on probation than within prisons, the health of this population has been subject to significantly less research. A small number of Health Needs Assessments (HNAs) for those on probation have been published, but to date none have focussed on APs. A previous HNA of people of probation in Nottinghamshire and Derbyshire found that offenders in the community access healthcare services at about the same rate as the general public, despite having significantly worse health. This suggests an unmet need in this population (Brooker, et al., 2015). Additional studies have demonstrated that people within the probation service have greater physical and mental health needs than the general population (Brooker, et al., 2009; Murphy, et al., 2017) with identified key risk factors being: smoking, excessive alcohol use, substance misuse, poor diet, excess weight and physical inactivity (Pari, et al., 2012; Cooper, 2018).

Whilst resident in prison, primary healthcare services are offered on-site and access is generally better than it was prior to incarceration (Condon, et al., 2007). Once released into the community, healthcare is provided on the same basis as it is for the general public thus presenting a potential interruption in care. Integrated Care Systems (ICS) in England and Local Health Boards (LHB) in Wales are responsible for planning and commissioning healthcare services to meet the medical needs of their populations which includes those subject to community sentences, on licence, or post-sentence supervision. Social care requirements are the responsibility of the local authorities. People in prison who are dealing with mental and physical health problems are significantly more likely to engage in prison misconduct than healthy prisoners (Semenza & Grosholz, 2019) and management of the health needs of offenders is likely to reduce the chance of reoffending (Davies, 2018). Therefore, in addition to the statutory obligation to cater for the health needs of the population and reduce inequalities, addressing the health needs of this population may have the additional benefit of reducing the community burden of reoffending.

Resident in APs arrive from the prison population, so research into prison health should act as a proxy for AP residents' health needs, although additional research is required to confirm that this assumption is valid. The demographics of those in prison is predominantly male, mostly aged in their 30s and 40s, is aging (the percentage of those 50+ has risen faster than any other age group), and is mostly white and British although minority ethnicities are over-represented (Sturge, 2022). Many of the determinants that are experienced by those with poorer health are similarly over-represented in those dealt with by the criminal justice system. These factors include lower socio-economic status, some ethnicities, experience of the care system, being of the male gender, experiencing poorer mental

health, having a learning disability, being unemployed, and experiencing substance misuse. In addition, having been subject to a custodial sentence is itself a determinant for poorer health (Mazzilli, 2019).

The health needs of those in the criminal justice system, as broken down by the National Probation Service's priority areas, are as follows:

Physical Health

The prevalence of many physical health conditions and communicable diseases are much higher in the prison population than the general population (Figure 3) (Revolving Doors Agency, 2018). Prisoners have far higher rates of dental disease and higher prevalence of untreated dental disease (Rouxel, et al., 2013; Heidari, et al., 2007). The prevalence of overweight and obesity in the prison population are lower than that for the general population, although still unacceptably high (Herbert, et al., 2012).

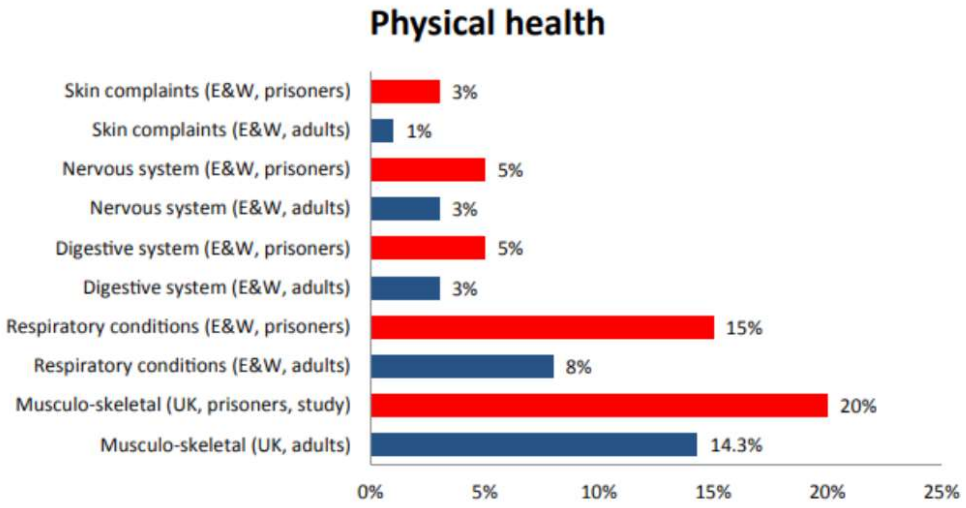

Figure 3 - rates of physical health conditions in England and Wales in prisoners and the general population (Revolving Doors Agency, 2018)

Learning disabilities and challenges (LDC) and autism

UK-based studies have shown the prevalence of learning and intellectual disability for those in custody to be 27% - 32% in young people (Kroll, et al., 2002; Rayner, et al., 2005) and 10% in adults (Hayes, et al., 2007) compared to a prevalence in the general population of 2.5% and 2.2% respectively (Public Health England, 2016). An additional third of adults in custody were considered to have a borderline learning disability. Those considered borderline may have difficulties in communicating and processing new or complex information yet fail to meet the criteria for assistance from the community learning disability services after release. This demonstrates a potentially unmet need.

Mental Health and Wellbeing

A range of mental health conditions including anxiety and depression as well as psychosis and personality disorders are seen at a much higher level in those in prison or on probation than the general population (Figure 4). One of the few studies of people on probation in the UK found that 39% had a current mental illness, 49% had a past/lifetime mental illness and 5% had an eating disorder, rates that were considerably higher than that seen in the general populations, and closer to levels seen within the prison population (Brooker, et al., 2012).

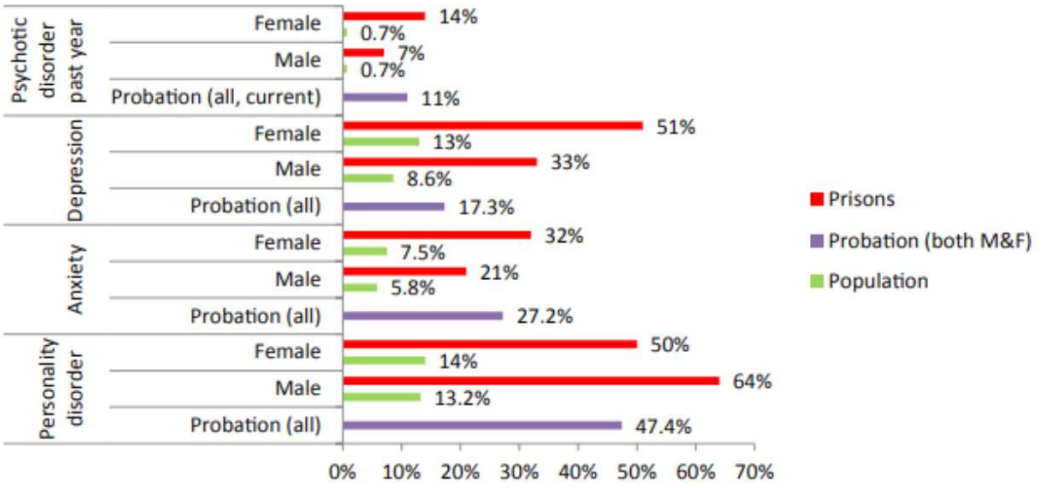

Figure 4 - rates of mental health disorders in prisoners and the general public (Revolving Doors Agency, 2018)

Suicide Prevention

Suicide disproportionally affects those in contact with the criminal justice system (Department of Health, 2009; Heide & Chan, 2018). Whilst that is true across the whole criminal justice system, the rate is highest for those who have recently left prison (Figure 5) (Phillips & Roberts, 2019; Pratt, et al., 2006; Phillips, et al., 2018). A review of suicide prevention across the UK criminal justice system has recently been conducted (Antunes, et al., 2021). It concluded that the implementation of suicide prevention strategies across the criminal justice system can be limited and highlighted a number of ways in which the service could be improved.

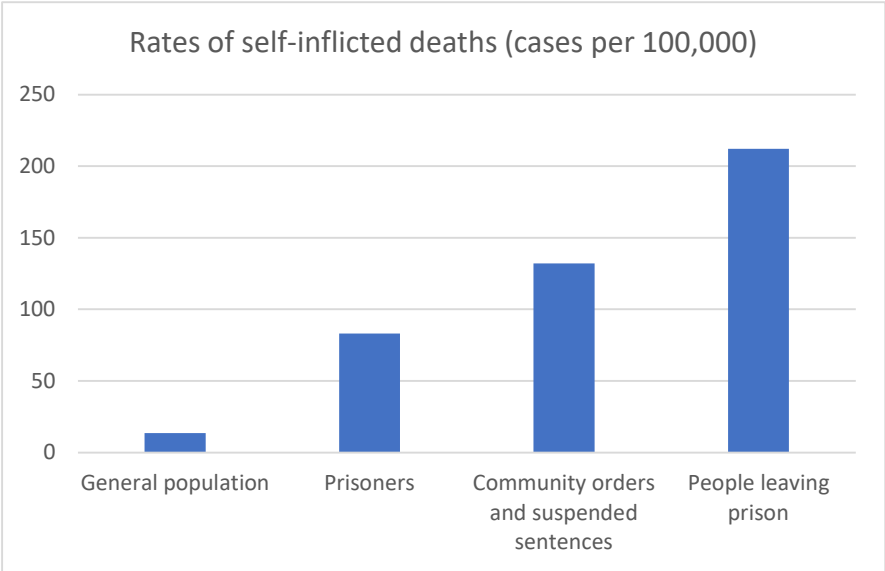

Figure 5 - rates of suicide (per 100,000) (Phillips & Roberts, 2019)

The Offender Personality Disorder (ODP) pathway

Estimates of the proportion of prisoners who exhibit personality disorder vary widely from a quarter (Rebbapragada, et al., 2021) to two-thirds (Singleton, et al., 1998). Whichever is the true figure, this greatly outweighs the prevalence in the general population of 5% (Singleton, et al., 2003). The Lincolnshire study of people on probation found that 47% had a probable personality disorder (Brooker, et al., 2012).

Substance Misuse

Substance misuse is found at many orders of magnitude higher in prisoners than the general population (Fazel, et al., 2006) and a similar picture is seen for alcohol dependence (Newbury-Birch, et al., 2009). Sixty percent of those under probation have been found to experience substance misuse problems (Brooker, et al., 2012). Tobacco smoking prevalence in prison had bucked the decreasing trend seen in the general population (Ritter, et al., 2011) prior to prisons becoming smoke free. Studies have revealed two-thirds of those in prison use e-cigarettes (vapes) (BCUHB, 2021).

Social care

The responsibility for the social care needs of adults in prisons was passed to local authorities in England via the 2014 Care Act, and local authorities in Wales via the Social Services & Well-being (Wales) Act 2014. Subsequent research has demonstrated that, whilst this brought about a substantial step forward in the provision of social care for offenders, the way in which social care and support were delivered to offenders was very variable (Tucker, et al., 2018). Provision of accommodation is currently a challenge in the UK and this has been experienced by those in the CJS with only 17% of prisons achieving the target for accommodation for prisoners on their first night following release (Ministry of Justice, 2023).

Chapter 3 - Study design

This HSCNA has four main objectives:

1. Assess the health and social care needs of AP residents.
2. Map the services provided to cater for those needs.
3. Perform a gap analysis to identify unmet needs of this cohort.
4. Make recommendations to improve the health and social wellbeing of AP residents.

A number of methodologies can be adopted when carrying out a health needs assessment. In broad terms, there are three approaches which can be used independently or in combination – epidemiological, comparative, and corporate.

The epidemiological approach utilises epidemiological techniques to assess the demographics of the population, their needs, the provision of services, and the effectiveness of those services.

The comparative approach compares the provision of services in the population under investigation with those provided for other similar cohorts.

The corporate approach seeks to collect the views and expertise of stakeholders in assessing which services are needed. The group of stakeholders can include professionals, experts, service-users, the public, and politicians.

For this HSCNA, a combined epidemiological and corporate strategy was adopted. The comparative approach was not possible due to the lack of prior research into APs.

3.1 Method

This HSCNA utilised a mixed methods approach to gather quantitative and qualitative data through the use of questionnaires, focus groups, and interviews to gather the views of service users (residents), AP staff members, and wider stakeholders.

Questionnaire for residents

A working group was convened to produce a questionnaire designed to understand the demographics of AP residents, their level of health and social need, and the services in place to satisfy those needs. The survey aimed to collect information on a number of health and social care topics, and used questions from national surveys where appropriate to allow comparisons to be made with the wider population. The topics examined were:

1. Physical Health.
2. Mental health, learning disability, personality disorder, and neurodiversity.
3. Health behaviours.
4. Social factors.
5. Demographics / equality monitoring.

After approval of the questionnaire by the working group, a pilot study was undertaken with a small number of residents in one AP and final amendments made based on their feedback. The questionnaire was then translated into Welsh. A copy of the questionnaire can be seen in appendix 1. It was possible to complete the questionnaire via an internet-based survey platform (SmartSurvey™) or on paper. A seven-day window for data collection was agreed with each AP, with support from an

AP or probation staff member to aid completion if any resident required assistance with reading, writing, or understanding the questions. Although the questionnaire was primarily designed to collect quantitative data, free text boxes were provided when appropriate for the answers to be expanded upon and thereby contribute to the qualitative data.

Resident focus groups and interviews

On the first date of data collection in each AP, the author and a colleague from HMPPS reducing reoffending team was present to carry out a focus group and individual interviews with residents. Information about the study was shared in written and verbal forms before written consent was gained. A copy of the information and consent form can be seen in appendix 2. In the focus group and interview, an initial statement was made about the aims of the study before the participants started the discussion. Additional questions were asked to aid focus of the discussions and to ensure all aspects of the topic were covered. The focus groups and interviews were audio recorded and transcribed before contributing to the qualitative data analysis.

AP manager and staff member focus group and interviews

The perspective of AP managers regarding the needs of AP residents was gathered via interviews conducted online with each AP manager via Microsoft Teams. The interviews were recorded and transcribed by the Microsoft Teams platform before corrections being made manually at which stage the recording was deleted.

The views of AP staff members were collected via a choice of focus groups or individual interviews depending on the views and workplace needs of each AP. Recordings were transcribed and analysed using thematic analysis.

Stakeholder survey and interviews

A stakeholder mapping exercise was undertaken to identify organisations and individuals who hold APs, or AP residents as part of their portfolio. The list grew organically as those invited to take part passed details on to colleagues who were more appropriately placed to respond. The full list of stakeholders can be seen in appendix 4. All stakeholders identified were sent a single page summary of the project and invited to take part in a very short online questionnaire, which can be seen in appendix 3. The survey was designed to gain engagement with the project, canvass headline views, and to identify individuals who would be willing to participate in an interview to explore issues in more detail. All those who indicated they would be happy to participate were invited to take part in online interviews via Microsoft Teams which were recorded and transcribed as previously described.

Data analysis

Quantitative data was stored in a Microsoft Excel spreadsheet, cleaned, before being subjected to statistical analysis. Thematic analysis of the qualitative data was carried out using the framework model (Gale, et al., 2013) whereby coding was used to identify themes and sub-themes. Gap analysis was used to identify which of the needs of AP residents were being met, and which were unmet.

Governance

This Health and Social Care Needs Assessment constitutes service evaluation and therefore formal ethical approval was not required. Full information governance principles were employed throughout. Informed consent was obtained from all participants and all data was stored securely on Public Health Wales's servers.

Chapter 4 – Results

4.1 Resident survey

The survey was completed by 53 residents representing 70% of the AP population. Breakdown by AP can be seen in

Table 1. All of the residents chose to complete the survey on paper copies which were then uploaded

	Completed surveys	Total population	%
Ty Newydd	11	16	69%
Plas Y Wern	13	18	72%
Mandeville House	14	18	78%
Quay House	15	24	63%
Total	**53**	**76**	**70%**

to an online survey platform (SmartSurvey) before being exported to a Microsoft Excel database for analysis.

NB not all stats will add up to 100% due to residents not answering a particular question or selecting the 'prefer not to say' option.

Table 1 – number of completed resident surveys by AP

	Completed surveys	Total population	%
Ty Newydd	11	16	69%
Plas Y Wern	13	18	72%
Mandeville House	14	18	78%
Quay House	15	24	63%
Total	**53**	**76**	**70%**

4.1.1 Demographics

Age

The age profile of the residents who completed the survey can be seen in Figure 6. Approximately half were aged 44 and below, with the 35-44 being the most represented age band. This age distribution is broadly in line with that for all those on probation in Wales.

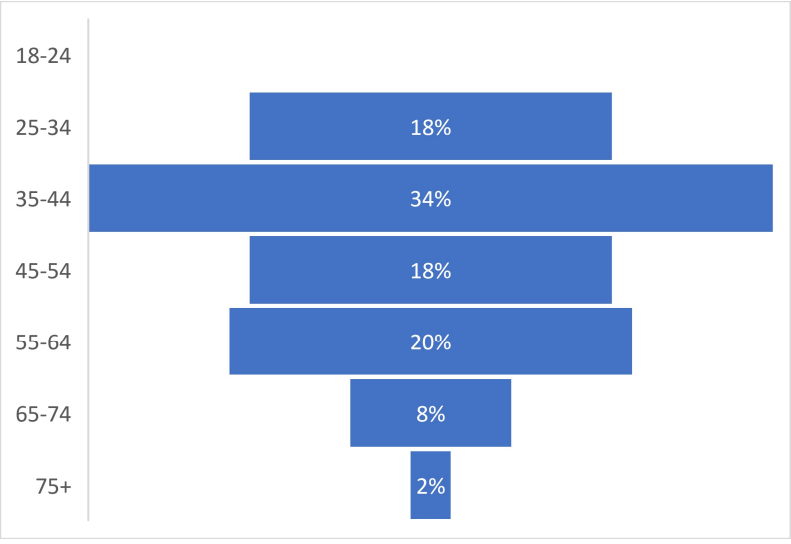

Figure 6 - age profile of residents who completed the survey

Sex

Fifty-one out of 53 residents answered this question. All were assigned as male at birth.

Gender identity

Of the 50 residents who answered the question on gender identity, 48 identified as remaining in the same gender assigned at birth, one had transitioned to the female gender, and one preferred not to answer the question.

Marital status

Forty-nine residents answered the question about marital status. Of those, the majority (63%) had never been married or in a civil partnership (Figure 7). One fifth were divorced, only 6% were married compared to 50.6% of the general population who are married or in a civil partnership (ONS, 2023).

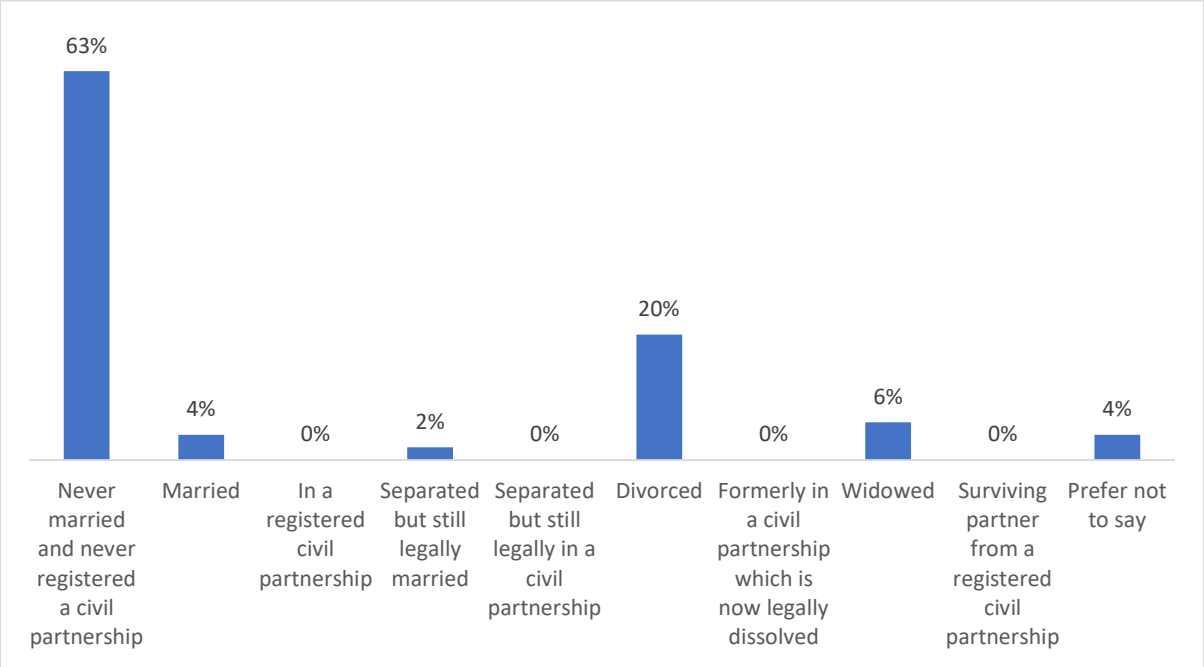

Figure 7 - marital status of residents

Ethnicity

Ninety-tow percent of respondents listed their ethnicity as White British, with one each identifying as mixed Asian and White, any other Asian background, Arab, and other. This is broadly similar to the general population.

Sexuality

Eight-three percent identified as heterosexual, 4% as gay, 4% as bisexual, and the remainder preferred not to say. This is in line with rates in the general population.

Main language

English was the main language of 48 out of 52 residents who answered this question, three were Welsh speakers and one spoke Kurdish.

Faith / religion

Thirty-eight percent of residents had no religion / were atheist, 36% were Christian, 2% were Jewish, 6% Muslim and the others had a different faith or preferred not to answer the question. This is in line with data for the general population.

Disability

Twenty-five percent of the residents who completed the survey identified as being disabled. This is similar to the level of disability in the Welsh population (ONS, 2023).

4.1.2 Physical health

The percentage of AP residents who self-reported a range of physical health conditions can be seen in Figure 8.

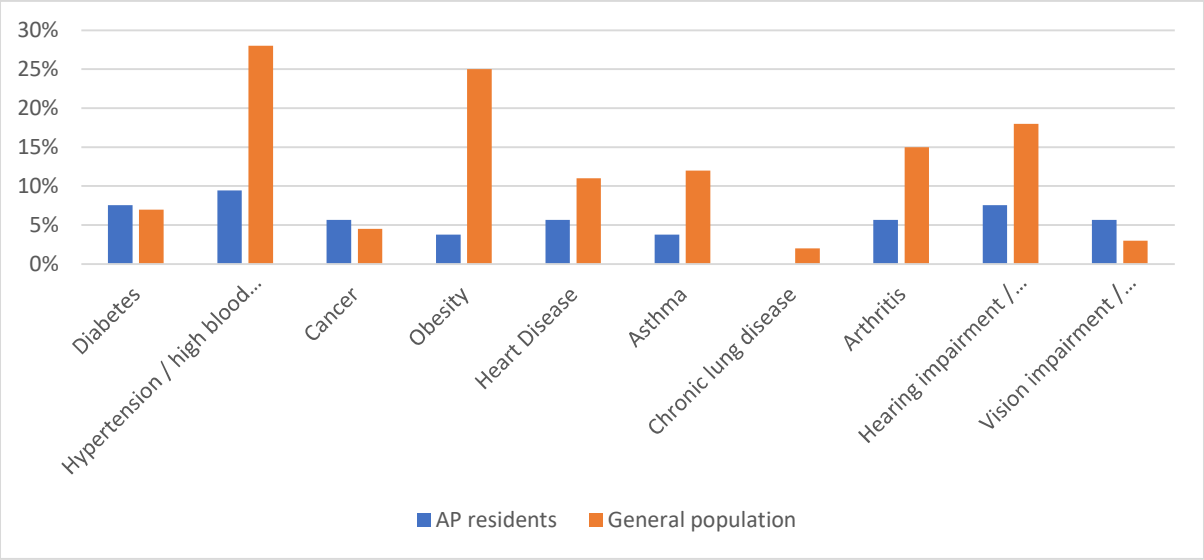

Figure 8 - percentage of residents who self-reported physical health conditions compared to the UK general population[1-10]

The results suggest that the rate of physical health conditions in this cohort of AP residents is at a rate similar or lower than that experienced by the general population. The lower rate of hypertension is in line with that reported by previous studies in a prison population (BCUHB, 2021). The rate of obesity (4%) is lower than the general population (25%) and that seen in a prison population (16%). Further research would be required to conclude if this is a true finding or due to it having being under-reported.

Thirty-eight percent of residents reported experiencing moderate or severe pain. 16% reported moderate or severe mobility problems. Fifty-eight percent of residents admitted to having a current dental problem.

Seventy-seven percent of respondents said their medical information had been shared with the AP on their arrival. Only one resident (2%) said that their information had not been shared. The remainder either did not have a medical issue, did not know if information had been shared, or preferred not to answer the question.

Seventy-four percent arrived at the AP with a supply of their medications, 11% did not have their medications, the remainder do not need medication or preferred not to answer the question.

---

[1] Diabetes data from (Whicher, et al., 2020)
[2] Hypertension data from (ONS, 2023)
[3] Cancer data from (MacMillan, 2023)
[4] Obesity data from (Welsh Government, 2020)
[5] Heart disease data from (British Heart Foundation, 2023)
[6] Asthma data from (NICE, 2022)
[7] Chronic lung data from (Snell, et al., 2016)
[8] Arthritis data from (NHSinform, 2023)
[9] Hearing impairment data from (RNID, 2023)
[10] Vision impairment data from (RNIB, 2023)

4.1.3 Mental health, learning disability, and neurodiversity

In contrast to physical health conditions, mental health disorders, learning disabilities, and neurodiverse conditions were all represented at higher levels than in the general population (Figure 9). Anxiety and depression were the most commonly reported mental health conditions with rates of 66% and 60% respectively. In terms of differences between the general population and AP residents, Autistic Spectrum Disorder and learning disability were the most over-represented with rates of 9.4 times, and 7.8 times the background rates respectively. Of note, PTSD was included in the 'other' section by four respondents (8%). That is twice the rate seen in the general population and is likely to have been under-reported since the condition was not explicitly asked about.

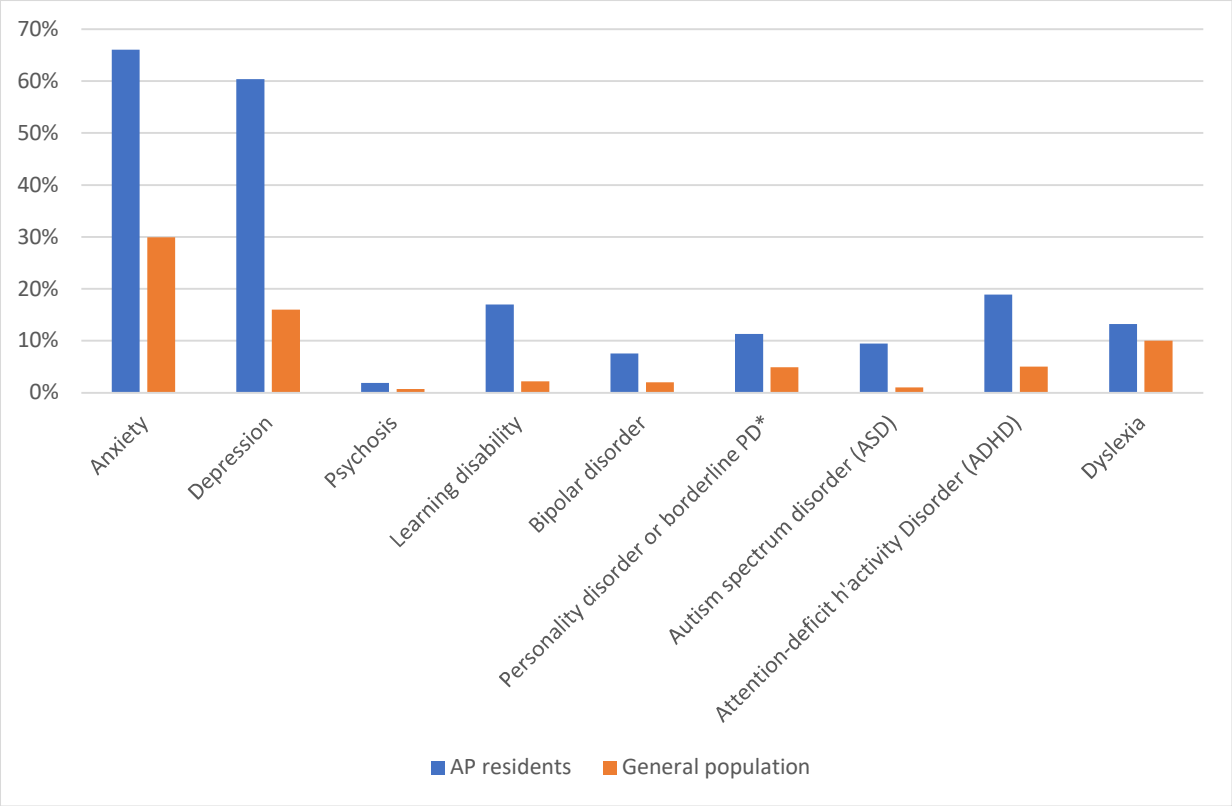

*Figure 9 - percentage of AP residents who self-reported a range of mental health or other neurodiverse conditions. Rates in the general population shown for comparison. *rate in males only*[11-18]

[11] Anxiety data from Mental Health Foundation
[12] Depression data from Census 2021 (ONS, 2023)
[13] Psychosis data from (Public Health England, 2016)
[14] Learning Disability data from Mencap
[15] Personality Disorder data from Adult Psychiatric Morbidity Survey 2014 (Moran, et al., 2014)
[16] ADHD data from 'Attention deficit hyperactivity disorder in adults' (BMJ Best Practice, 2017)
[17] Dyslexia data from NHS (NHS, 2022)
[18] Autism Spectrum Disorder data from BMA (BMA, 2020)

4.1.4 Alcohol

Twenty-eight percent of residents admitted that drinking alcohol had caused health problems, and 26% said that alcohol had led to them offending. In total, 23 residents (43%) said that alcohol is, or had been, a problem for them.

4.1.5 Tobacco smoking

Thirty-eight percent of residents reported smoking tobacco and an additional 34% indicated that they used to smoke but had given up. There was a marked difference in the rate of smoking between the different APs (Table 2). Only six residents indicated that they would like additional support to quit smoking and all of those were resident in Ty Newydd, the AP with the highest rate of tobacco use.

Table 2 - rates of tobacco smoking

	Yes, I smoke now	I used to smoke but I have given up	I have never smoked
Ty Newydd	64%	18%	18%
Plas Y Wern	54%	31%	15%
Mandeville House	21%	29%	36%
Quay House	20%	53%	20%
Overall	**38%**	**34%**	**23%**

4.1.6 Vapes / E-cigarette use

Fifty-eight percent of residents who completed the survey reported using vapes, a rate that was consistent across the four APs (Table 3). This is considerably higher than the rate of vape use in the general population which is estimated to be 8.3% (ASH, 2022) but in line with the rates of vape use in prison (BCUHB, 2021).

Table 3 - rates of the use of e-cigarettes / vapes

	Yes	No
Ty Newydd	64%	36%
Plas Y Wern	54%	46%
Mandeville House	57%	43%
Quay House	60%	27%
Overall	**58%**	**38%**

Of the 31 residents who are currently using a vape, 52% are current smokers, 39% are former smokers, 3% have never smoked (Figure 10).

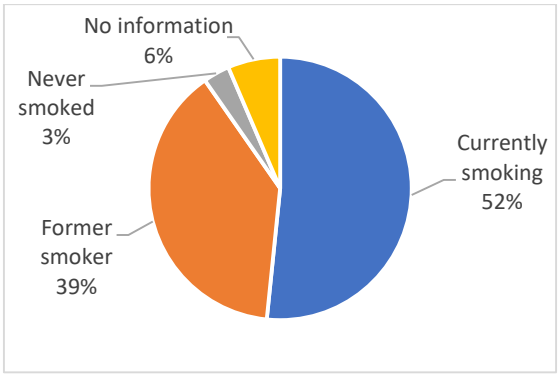

Figure 10 - rates of smoking in people currently using a vape

4.1.7 Drugs

Twenty-eight percent of respondents reported that the use of drugs had caused problems in the past, and 25% said drugs had led to offending (Table 4). In total, 34% of residents who completed the survey said that drugs had been a factor in their offending. A small minority thought that drugs would be an issue for the future and a similar number wished to receive support to avoid drug misuse in the future.

Table 4 - use of drugs for AP residents

	Has using drugs caused problems for you in the past?	Has using drugs led to you offending?	Are you worried that drugs will cause problems for you in the future?	Are you receiving support to stop using / avoid drugs?	Would you like support to stop using / avoid drugs?	Prefer not to say
Ty Newydd	45%	36%	9%	9%	9%	9%
Plas Y Wern	38%	31%	8%	8%	15%	8%
Mandeville House	14%	21%	0%	14%	7%	7%
Quay House	20%	13%	7%	7%	7%	13%
Overall	**28%**	**25%**	**6%**	**9%**	**9%**	**9%**

4.1.8 Gambling

One in six (17%) had gambled more than they could afford. Only two residents (4%) were worried about gambling in the future and only one resident said he wanted support for gambling.

4.1.9 Food in the AP

Over 80% of residents were happy with the food that was provided within the AP, and 70% felt they were eating a healthy diet. Overall, 72% felt they had a choice of healthy food within the AP, although the figure was only 36% in Mandeville House.

Approximately half of the residents had been able to get involved in growing their own food (Table 5), but that was mainly in the APs in North Wales which are in more rural locations and have more land available for such activities.

Table 5 - percentage of residents able to get involved in growing food at the AP

	Yes	No
Ty Newydd	82%	9%
Plas Y Wern	92%	8%
Mandeville House	7%	86%
Quay House	27%	73%
Overall	**49%**	**47%**

Thirty-four percent had received advice on how to eat healthily whilst they have been resident in the AP, and 40% indicated that they would like advice on healthy eating.

4.1.10 Exercise

Seventy percent of residents said they were exercising every day or on most days (Table 6). Thirteen percent said that they never got any exercise.

Table 6 - replies to the question 'how often do you exercise?'

	Every day	Most days	1-2 times a week	Never	Prefer not to answer
Ty Newydd	55%	27%	9%	9%	0%
Plas Y Wern	23%	46%	23%	8%	0%
M'lle House	21%	50%	7%	21%	0%
Quay House	47%	13%	20%	13%	7%
Overall	**36%**	**34%**	**15%**	**13%**	**2%**

Walking was the most common type of exercise undertaken, being enjoyed by 81% of residents across the four APs. The on-site gym was used by 34% of respondents with cycling (21%), running (17%), and gardening (11%) having a lower level of participation. The average for cycling was influenced by the high percentage of participation (43%) in Mandeville House where there is an on-site bicycle repair workshop and a member of staff who is particularly interested in that activity.

Eighty-seven percent of those who completed the survey thought that local walks were important, with organised trips, provision of the on-site gym, and gardening being deemed important by 72%, 66%, and 53% respectively (Figure 11).

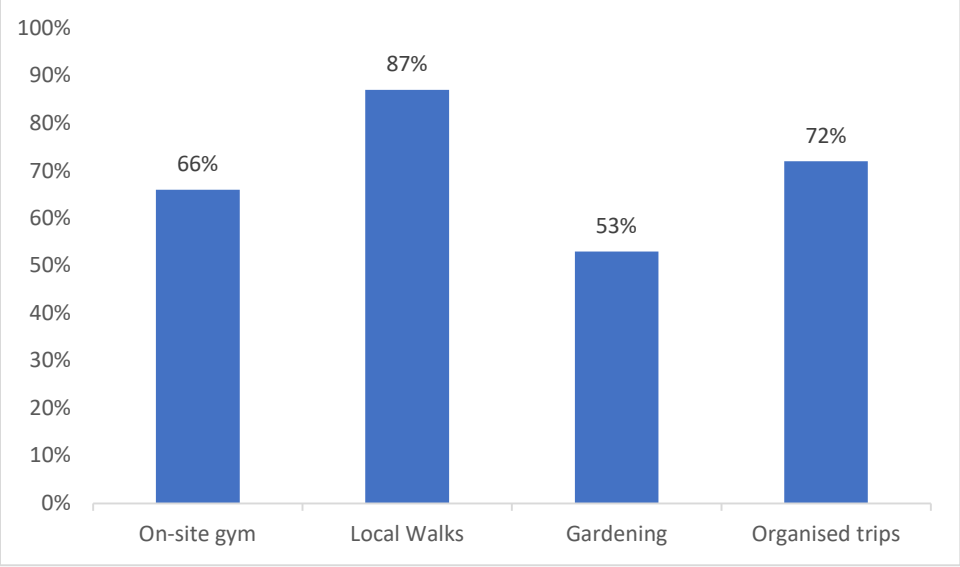

Figure 11 - percentage of residents who feel the activity is important

4.1.11 Access to healthcare services

Eighty-five percent of those who completed the survey said they were registered with a General Medical Practitioner, whilst only 13% were registered with a General Dental Practitioner. Of those who had required appointments with medical professionals, the vast majority had been able to secure appointments (Figure 12). Residents reported a high demand for appointments with mental health services, but 28% had been unable to secure an appointment. Seventy-five percent of those who needed the services of a dentist had been unable to get an appointment.

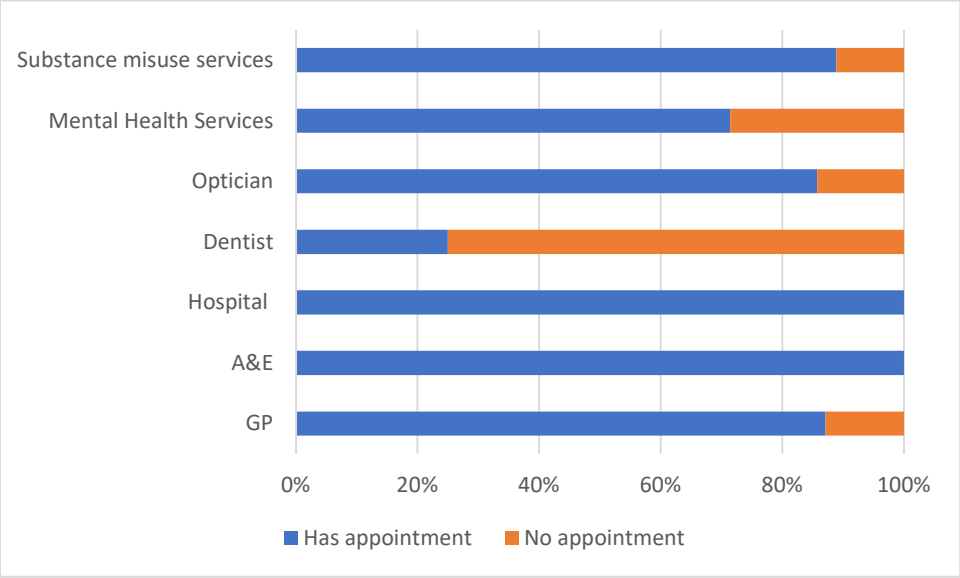

Figure 12 - percentage of those who need appointments with healthcare services that have been successful in booking an appointment

4.1.12 Social care

Only 23% of respondents knew where they would be living after release from the AP whilst 75% did not know where they would be living. One participant did not answer this question. Of those who did know where they would be living, the majority expected to be going to an address that was new to them. Two were going back to their old home, and one was expecting to be homeless on release. Sixty-four percent said that they felt worried about where they would be living on release.

Seventeen percent of residents said they had experienced or witnessed discrimination or bullying, with age, ethnicity, gender identity, and religion being the reasons given for that discrimination.

Eighty-three percent of residents had people outside of the CJS who were offering support to the resident, with that support coming mainly from parents (43%), siblings (43%), and friends (32%). Seventy-six percent of the residents said it was easy to stay in contact with the people who supported them, 15% said it had been difficult to stay in touch, and 9% did not know or did not answer the question.

Thirty-two percent felt lonely, 55% felt connected to others with the remainder preferring not to answer the question. Thirty-four percent said they were worried about being lonely after their release from the AP.

Eight-seven percent had been able to sort out their source of income, with 81% having received support regarding finances whilst in the AP. Twenty-eight percent felt they needed more support with their finances. Six percent had a job waiting for them on release from the AP. Forty-three percent

aimed to look for paid employment and 8% were planning on volunteering. Twenty-six percent felt they needed help in looking for employment.

4.1.13 Overall

Sixty-six percent of residents felt that all of their needs were being met, and 32% felt that some of their needs were being met in the AP. No respondent felt that none of their needs were being met.

4.2 Stakeholder survey

Following an exercise to map partners who have APs as part of their portfolio, a list of stakeholders was produced and can be seen in appendix 4. It proved difficult to identify appropriate participants in some sectors including the Health Boards.

A short questionnaire was sent by email to all stakeholders and completed by 24 participants. The areas of work for those who completed the survey were varied and can be seen in Figure 13. Only one stakeholder from the health sector participated.

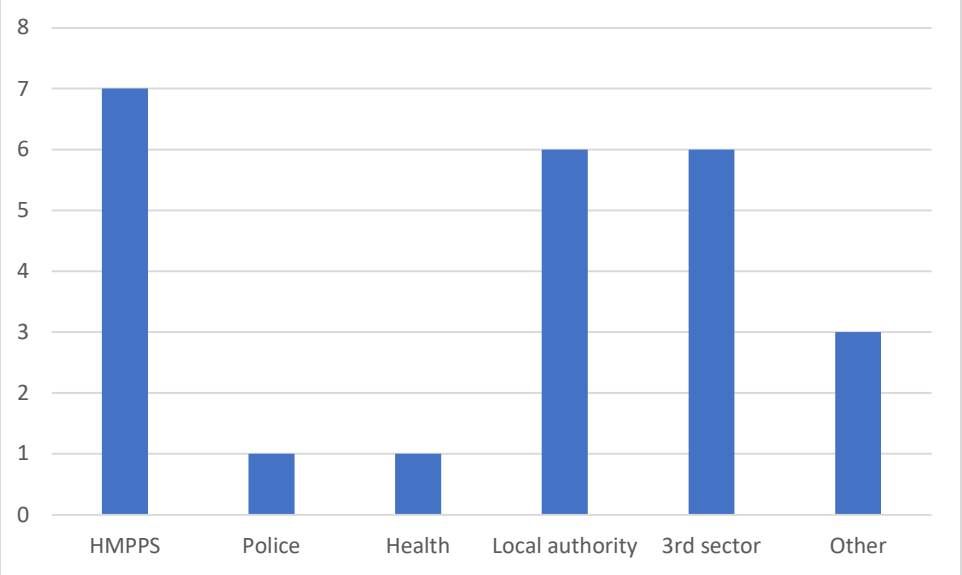

Figure 13 - sectors of the stakeholders who completed the survey

The majority (n=16, 67%) of those who completed the survey dedicated part of their time to working with AP issues, 12% worked mostly with APs, 4% worked exclusively with APs, and 17% devoted none of their time to APs. (Figure 14).

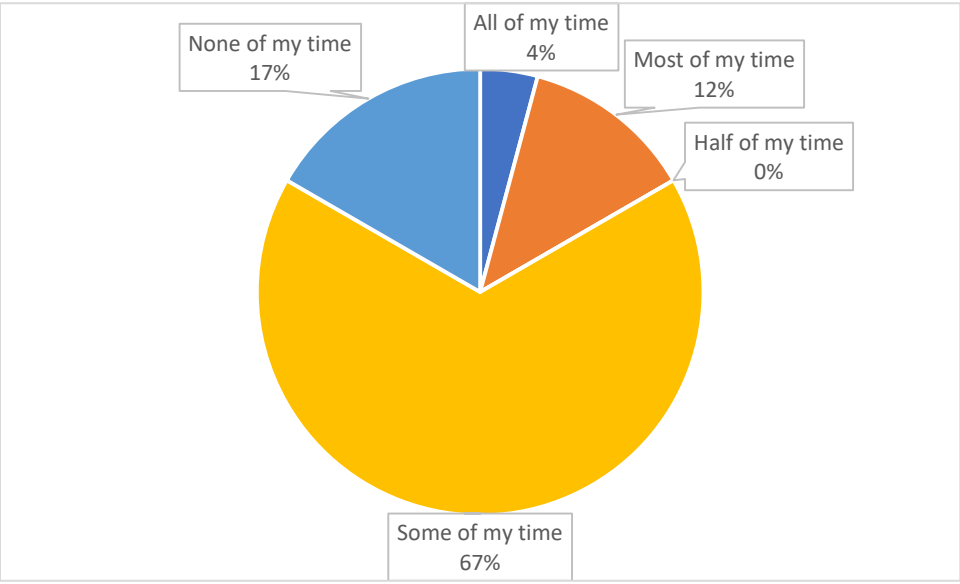

Figure 14 - stakeholder's time dedicated to AP issues

Stakeholders were asked to rank mental health, substance misuse, housing, employment, education, physical health, learning disability, and personality disorder in the order of priority of need for AP residents. Mental health, substance misuse, and housing were the clear priorities.

When considering unmet health and social care needs, 88% of stakeholders indicated that mental health needs were not being met, with housing (54%) and learning disability (46%) following.

Twelve stakeholders from a variety of backgrounds which include HMPPS, offender faith services, brain injury services, local authority offender housing services, local authority social services, third sector offender housing, Welsh Government, and His Majesty's Inspector of Probation, indicated they would be happy to participate in an interview to provide a better understanding of their views. Interviews were conducted as previously described and contributed data to the qualitative analysis reported below.

4.3 Qualitative data collection

One focus group for residents was undertaken in each AP and interviews were carried out with individual residents who wished to take part but were not comfortable or able to be included in the group. A total of 17 residents took part in the focus groups, and three residents agreed to take part in individual interviews. Staff members from all APs, including all four managers, took part in focus groups or interviews depending on their preference and work patterns. Twelve stakeholders agreed to take part in online interviews via Microsoft Teams. All participants who took part were provided with information about the study and gave their consent to participate.

Participants were asked to express their views about the health and social needs of AP residents, the services provided, and for their opinions about how systems could be improved to better meet those needs. All interviews or focus groups were recorded, with permission of the participants, and transcribed before being subjected to thematic analysis utilising the framework analysis method (Gale, et al., 2013). After analysis, the data could be compiled into the following themes:

Theme 1 – Overall View of APs

AP residents overwhelmingly felt that APs, and especially the staff members within APs, provided a very supportive environment and that every effort was made to look after their wellbeing. They felt that staff members did everything within their power to assist with issues related to healthcare, rehabilitation, and move-on from the AP. Residents expressed an overwhelmingly positive opinion of AP staff members.

Residents and staff both expressed a high level of frustration with the systems provided to cater for health and social care needs of AP residents, but both groups felt that the majority of frustrations were due to deficiencies with the wider health and social care system, and therefore outside the immediate control of the AP.

"All the staff members are approachable" - Ty Newydd resident

"…but the staff, they do their best" – Ty Newydd resident

"The staff are pretty helpful, like if you ask them something, they're pretty good at helping" – Plas Y Wern resident

"They always make it clear that they're there if you want them" – Quay House resident

Theme 2 – Mental Health / Neurodiversity

Mental health and neurodiversity were almost universally identified as the biggest health need for AP residents and one of the priority areas representing an unmet need. Factors fell into two broad topics: the services in place to treat mental health or neurodiverse conditions, and the mental health effects of moving into the AP, through the system and into the wider community.

The issues relating to mental health and neurodiverse conditions fell into a number of sub-themes:

- Residents with mental health conditions generally felt that their condition was managed well within the prison system, but the ability to access mental health services within the community or secondary care system was a challenge. Such patients feel that they fall out of the system and have to start the referral process again. This seems to be the case even when the prison and community mental health services are within the same local health board.

- The waiting list for local community or hospital mental health services was frequently longer than the total duration of stay within the AP.
- The provision of medications for mental health / neurodiverse conditions is frequently insufficient to cover the time for a new supply to be established from the health service. This serves to destabilise residents at a time of heightened mental health need. This disparity was not known to prison mental health services. Medicines management is described in more details below.
- When residents with conditions such as ADHD and psychosis present to the GP, they frequently find that the GP is unwilling to re-prescribe medications for those conditions. This leads to a referral to secondary care which would be unable to be fulfilled within the time at the AP and a further delay to the supply of medications.
- The number of residents who feel they need treatment from mental health services is far larger than the number identified by the healthcare system as meeting the threshold for that treatment.
- Staff members and stakeholders felt that the failure to adequately address mental health conditions amongst AP residents leads to additional challenges with other aspects of the system e.g. a reduced ability to find and keep accommodation, a higher likelihood of substance misuse, and a higher chance of reoffending.

"They don't accept referrals until literally like they are minutes away from harming themselves. They don't have preventative measures, it's all reactive" – AP staff member

"In the AP world, we're putting people on 'cares', doing all these observations and stuff when we're not mental health workers or trained, and we're just doing the work of the mental health team really" – AP staff member

"I think the staff should go through some [mental health] training" – Plas Y Wern resident

Issues related to how the system contributes to poorer mental health of AP residents can similarly be broken down to the following sub-themes:

- Many residents had a very negative view of the AP before leaving prison, which had a detrimental effect on their mental health. In many cases, this prejudice was from discussions with fellow prisoners who had been in the AP and subsequently been recalled to prison. The prevailing view is that APs are places designed to catch residents out so that they can be recalled, rather than as a stepping stone to the community and as a place for continued rehabilitation. In reality, the majority of residents find APs to be much better than they anticipated, both in terms of the physical environment as well as being a place for rehabilitation.
- Both AP staff and residents feel there are benefits in establishing relationships early, although this is not always possible. Some PSOs are able to visit incoming residents before the end of their custodial sentence to start the relationship, find out about the best way to support the resident, and to alleviate any anxiety. Such visits are viewed by both parties to be very valuable but are not always possible due to insufficient notice, the resident being in a prison that is not local, or for staffing or capacity issues within the AP.
- The mental health effects of matters related to accommodation (see below).

"I think what they should do is make a film." – Plas Y Wern resident

"They get your mental health good here… but now you're getting closer and closer to the date when you're going out and the anxiety is starting to rise again…" – Quay House resident

Theme 3 – Accommodation within the community

The provision of accommodation following release from the AP presents a number of significant challenges which can be summarised into the following sub-themes:

- Not knowing where the resident is going to be housed is a source of additional anxiety, especially if the lack of suitable housing leads to an extended stay within the AP.
- The constrained availability of accommodation is an issue throughout the country and is experienced both in the social and private-rental markets.
- Local authorities are often unable to start discussions about housing residents until shortly before the expected day of release. This adds to the anxiety experienced by the resident.
- It is not uncommon that the local authority is unable to offer suitable accommodation on the anticipated date of release which leads to extension to the stay within the AP due to a social rather than risk-management reason. This has implications both for the mental health of the resident, and for the flow of residents through the AP.
- On occasion, residents are released from the AP to being street homeless. Anecdotal evidence suggests that residents in such circumstances often relapse into substance misuse or offending behaviour and recalled to prison.
- A number of residents felt that their views are not taken into consideration about the location of residence on release. For example, a number felt that being housed by their own local authority was a threat to their rehabilitation since that would potentially involve moving back to the location of their offending, and a perceived increased risk of reoffending.
- The Community Accommodation Service (CAS) for temporary provision of accommodation for those leaving the criminal justice system is inconsistently applied throughout Wales with only half of local authorities having CAS3 accommodation, although this is due to increase in the coming months.
- Temporary accommodation on release frequently houses a number of people with similar histories of offending or substance misuse together which is not conducive to rehabilitation.
- With high demand for accommodation and constrained supply, AP residents often find themselves at the bottom of the list in both the private-rental and social markets due to their offending past, especially if that includes sexual or violent crimes, and an inability to demonstrate a recent history of paying rent and being a good tenant. This serves to make provision of stable accommodation less likely for those at greatest need.

Re moving to a house of multiple occupancy: **"You're in an environment where there's a lot of drinking and lots of drugs. You're put into [accommodation] with a higher risk of relapsing and doing stuff like that. It's a bit cheeky, sort of, to chop up a house and call it single flats"** – Quay House resident

"That's a worry as well because you get a set time here and when you're coming up to that time and your brain's going, like, am I staying or am I going?" – Plas Y Wern resident

"I was looking forward to the last four weeks, get it over with, and then two days before [that date] she phoned me to say I've got an extension" – Plas Y Wern resident

Re being moved to temporary accommodation: **"If you don't have a [permanent] place for me, don't move me from here"** – Ty Newydd resident

"[Housing] is a major obstacle in terms of moving on and it stresses the lads out as well" – AP staff member

"They think 'I'm only here for X amount of weeks' and then X weeks fly by and then we have to tell them that there is no housing for you, you've been extended here for another four weeks, which you know obviously impacts on their stress levels and wellbeing and mental health" – AP staff member

Theme 4 - Medication Management

All APs have a system of storage and administration of residents' personally prescribed medications, which may include the dispensation of opioid substitution treatment when external substance misuse services are closed, for example at weekends. The APs' system of dispensing medicines generally works well. Issues with the system for providing medications fall into the following subthemes:

- The supply of medication provided by the prison to the resident is not always of sufficient duration to cover the gap until a new supply can be sourced within the community. Gaps in the supply of a medication can have severe detrimental effects on residents, especially when prescribed for mental health conditions. As residents themselves stated, there is little risk from missing a couple of days of blood pressure medication, but any gap in the provision of mental health medications can have a profound and immediate effect.
- Prison regulations, on release, prisoners can be supplied with a maximum of a seven-day supply of medication (although AP residents reported receiving two weeks supply). Prison prescribers were not aware of the time it takes for supplies to be re-established within the community. There is no mechanism for a longer supply to be provided, and there would be additional risks from giving a larger supply of medications that could be sold as substances of misuse, or could be dangerous in overdose. There is no mechanism for such medications to be sent directly to the AP or local pharmacy in an attempt to avoid discontinuation of supply.

"When you leave prison, they only give you two weeks of medication" – Ty Newydd resident

"I ran out after the second week here, so that was a learning curve because I've never come off antidepressants before so, you know, that was difficult" – Ty Newydd resident

Theme 5 – Links not System

Each AP had close connections with several outside providers who offer support to residents in areas such as substance misuse, mental health, social care, and outdoor activities. Many provide their services within the AP on a regular or ad-hoc basis as appropriate. Sourcing those outside agencies had frequently come about due to proactive actions of the AP manager rather than being due to a process being in place. As one manager eloquently stated, these relationships come about due to "*links not system*". This lack of universal provision of services has led to the range of services on offer varying considerably between APs and some external providers operating outside of their job description to try to plug any gaps. One example of this is a social worker who has proved invaluable in arranging for prompt mental health interventions on an urgent basis when required.

Theme 6 – Rehabilitative Activities

Residents and staff members alike from all APs greatly value rehabilitative activities such as trips out of the setting, organised walks, woodland projects, or spontaneous barbeques when the weather allows. Such activities offer social as well as behavioural benefits for the residents, and improved wellbeing for both staff and residents. The recent appointment of a Partnership and Stakeholder Lead for Approved Premises in Wales has been met with universal approval of the extra value that he can add to the ability to provide these activities and tie the AP in with external partners. However, the ability of each AP to facilitate such activities varies considerably and is subject to a number of factors:

- Sufficient staffing capacity above the minimum level is required to facilitate such activities. This capacity varies between APs, especially when the impact of long-term staff sickness is taken into account.
- The access to transportation varies between setting with some having ready access to a minibus whilst others do not. This would mean that whilst one setting can easily organise a trip, another would need to find funds to pay to hire a minibus.
- Access to funds, APs no longer hold petty cash and therefore such activities need to be booked in advance and are unable to be provided spontaneously, such as a barbeque when the weather is nice. This has led to a feeling that staff on the ground are not trusted to make such decisions.
- Many contributors felt that there was a need for a 'moving on' course designed to prepare residents for going back to the community after a number of years living within the custodial system. Such a course could include managing finances, keeping a home, and general life skills.
- Most residents felt that they had good connections with family or friends within the community. However, this was much more difficult for residents who had been placed outside their home area.

4.4 Gap analysis

Gap analysis identified the following mismatches between need and services offered:

Mental health

There is a considerable mismatch between the number of residents who feel they need treatment for a mental health condition (the demand), the number that the health services identify as requiring treatment (the need) and the ability to supply mental health services within the time that residents are present in the AP (the supply).

Medication

The supply of prescribed medications does not always cover the gap until a new supply can be sourced.

Accommodation

The provision of suitable accommodation within the community for AP residents to move in to is in very short supply. That constraint leads to AP residents often not knowing where they will be moving to which serves to increase anxiety in this population with high rates of poor mental health, and can be the cause for the stay in the AP to be extended. The provision of emergency accommodation through local authorities or the CAS to prevent former offenders becoming homeless is similarly in short supply. When accommodation is available from private landlords or third sector social providers, AP residents are frequently at the bottom of the list due to their offending history, which may be sexual or violent in nature. This serves to further widen the inequality in access to accommodation for this vulnerable population.

Purposeful activities

The ability for PSOs to provide purposeful activities for residents is sometimes constrained by staffing levels within the APs, for example when a PSO is required to man the front desk to maintain the minimum staffing level.

Both residents and staff members value external activities, however each AP's ability to provide such activities with the frequency they would like to is limited by factors such as staffing levels, access to transportation, and access to readily available funds.

Access to dental services

There is a high level of untreated dental disease amongst AP residents. The majority of AP residents are entitled to free NHS dental care so personal finances is not the barrier to entry. Only one in 14 NHS dental practices in Wales are currently taking on new patients, and the temporary nature of the residents' stay acts as a barrier to treatment.

Universal offer

The services available within each AP differs by location and have mainly come about by the actions of the manager than by there being a nationwide blueprint to ensure provision of a universal offer.

Chapter 5 – Discussion and Conclusions

This study has been invaluable in improving our understanding of the health and social care needs of residents in APs in Wales as well as evaluating how well current service provision caters for those needs.

Limitations of the HSCNA

The results from this HSCNA are based on self-reported data from the small cohort of residents who were present during the data collection period. Fifty-three residents completed the survey which represented 70% of those present on those dates. Whilst this is a good return rate, it is not known if the needs of those who did not take part are materially different. Similarly, the 20 residents who participated in the qualitative data collection were not selected randomly and therefore may not be representative. However, the results are broadly in agreement with studies carried out on people within the wider CJS and, in addition, have highlighted issues specifically applicable to the AP context. Therefore, this HSCNA does provide a valid basis on which to formulate conclusions and to make recommendations.

Health Conditions

Mental health and neurodiverse conditions represent the biggest health need of AP residents, and also the largest mismatch between demand and provision of healthcare services. The gaps in service provision are:

1. The provision of medications on release from prison is not always sufficient to cover the time until a supply can be re-established in the community. This access to medication is sometimes extended further by GPs not being content to re-prescribe some psychoactive medications necessitating referral to specialist services.

2. Those residents under the care of mental health services within prison feel that they have to start again when back in the community.

3. The waiting list for referral to hospital or community mental health services is often longer than the whole duration of stay within the AP.

Physical health conditions were found at a level equivalent to or lower than that seen in the general population. This may be a true finding or may be a reflection of the younger age of AP residents with relatively few being in the older age categories where most physical health conditions become more prevalent. This HSCNA does not have sufficient participants to present age standardised results. This HSCNA did not conclude that access to primary and secondary medical care for physical health conditions was a problem for any condition apart from access to dental care.

There is an unmet need for dental treatment amongst AP residents. Research carried out by the BBC in 2022 found that 93% of dental practices in Wales who undertake NHS treatment were no longer accepting new patients (BBC, 2022). The majority of AP residents will have moved area, and therefore have no relationship with local dental practices, thereby necessitating the need to join a waiting list to be able to register as a new patient.

Health behaviours

The rates of smoking and vaping were both found to be considerably higher in AP residents than the general public. Smoking is not allowed in prisons within the UK, therefore the 38% of residents who are currently smoking represent people who have recently started or restarted the habit. An additional 34% of residents were former smokers. It would be interesting to conduct longitudinal research to evaluate how many of those take up smoking, and to evaluate which interventions within prison or the community achieve the most sustained reduction in smoking rates. It is often stated that stress and boredom are motivations for smoking, so it is possible that the additional anxiety caused by moving through the AP system or a lack of regular activities account for the number of smokers. Vaping was reported in 58% of residents which is similar to the percentage who vape within prison. Whilst the use of e-cigarettes is thought to present a lower risk to health than cigarettes, the long-term consequences are only just starting to be understood. Vaping is commonly used as part of a suite of interventions to reduce the rate of smoking tobacco products, and this study found that 39% of those who used a vape were former smokers. Unfortunately, it also demonstrated that 52% of vape users were also smoking.

The rates of physical activity within the AP was found to be high, with 70% of residents taking exercise on most days. Only 13% reported never taking any physical activity. This is in contrast to previous studies of people on probation. Residents appreciated the on-site gym as well as opportunities to go outside for a walk, to take part in gardening, or to participate in organised trips. The ability for AP staff to facilitate activities was constrained by staffing capacity, access to transportation, and access to petty cash to fund spontaneous activities.

Residents were found to have relatively high historic levels of problematic alcohol use, gambling, and substance misuse. The survey did not ask about current behaviours since licence conditions would preclude such activities and it was not thought to be appropriate to encourage anyone to incriminate themselves. Each AP works closely with substance misuse services and often dispenses opioid substitution treatment when local services are closed, for example at weekends and on bank holidays. Information was not gathered about the availability of gambling support services, but access to such would be valuable.

Eighty percent of residents were happy with the food that was provided within the AP with 72% feeling that there were healthy options available. Just under half of residents had been able to participate in growing food, but this was seen mostly in the APs in North Wales which were on much larger plots with space for such activities. Residents who were able to grow their own food gained a lot of satisfaction from doing so. The ability for the city-centre APs in Cardiff and Swansea to offer participation in growing food is constrained by having much smaller outdoor areas. Perhaps the acquisition of an allotment, or participation in a food growing project within the community would afford the ability to offer similar physical and mental health and wellbeing benefits, but of course would be subject to the ability to fund such an activity and provide staff capacity to facilitate it.

Social needs

Approved premises are a stepping stone to residents being housed back within the community, yet the lack of provision of suitable accommodation on either a social basis or on the private rental market serves to increase the level of anxiety, and on many occasions can lead to an extended stay. Discussion with housing officers from one local authority who work exclusively with the accommodation of former offenders added very valuable context to better understand constraints that exist within the system. On release from an AP, residents move on to one of the following:

- Back to a former address
- Temporary accommodation through the Community Accommodation Service (CAS).
- Temporary accommodation through the local authority
- Permanent accommodation in a local authority property
- Accommodation through third sector social housing provider
- Private rental property
- Being homeless

Aside from a resident's own property, all types of accommodation are experiencing severe challenges in being able to balance supply and demand. The CAS was introduced in June 2022 for the temporary accommodation of people leaving prison or an approved premises who might be at risk of homelessness. CAS2 is for people who present low to medium risk. CAS3 is for anyone leaving prison at risk of being homeless regardless of risk and is therefore more appropriate for the majority of AP residents. There are currently 120 beds spaces within 11 local authority areas which supply CAS3 level accommodation, on the basis of need, for up to 84 nights. The capacity will soon increase to 165 bed spaces. The very limited supply of local authority owned accommodation means that many residents must find somewhere to live either from a social housing third sector provider or on the open market. Unfortunately, residents who move on from APs experience discrimination from landlords due to their offending past, especially if that offending is of a sexual or violent nature. In addition, residents would not satisfy the requirement to provide references from recent landlords or demonstrate a history of being able to pay the rent and being a good tenant.

It is not common for residents to leave an AP to no fixed abode, but it does happen. During the data collection period, the author learned about one resident for whom the plan was for them to be released in December to live on the street with a tent provided by the local authority. Another resident was advised by their local authority that they would need to be street homeless for a number of nights before they could be considered for accommodation. Both incidents were in the same AP and under the same local authority. Unfortunately, it was not possible to interview representatives from that local authority to identify if that area was experiencing an exceptional demand for housing.

Moving into the AP

The process of moving into an AP after a long stay in a prison causes considerable additional anxiety for many residents. Many report having heard alarming stories whilst in prison about how the AP will look for any excuse to recall the resident back to prison. In many cases, these stories come from former residents who had themselves been recalled. The majority of residents were pleasantly surprised at how positive and supportive the environment was in reality. Many PSOs try to visit residents before the end of their custodial sentence to learn more about their needs and to start the process of acclimatisation to the AP, however this relies on having sufficient notice that a resident is going to be coming, the resident being in a local prison, and having sufficient staff capacity to allow such visits to happen. Whilst an information pack is sent to residents, many expressed that having access to a video tour would have alleviated much of the additional anxiety. Such a tour could show the physical

environment, introduce the staff members, and demonstrate rehabilitative and social activities within the AP. It could be made with the involvement of current or former residents and current staff and thereby its production could serve as purposeful activity.

AP staff members

APs are staffed by a very dedicated workforce who sees value in its work in rehabilitating this group of challenging, high-risk offenders. However, staff members do feel frustrations with the system as it currently stands which have an impact on the ability to perform their duties adequately, and which contribute to low morale. More details on workforce wellbeing can be found in the Workplace Wellbeing Needs Assessment that accompanies this report.

AP staff feel detached from the wider probation system and feel that they could be integrated more into the wider offender management system. They build close relationships with residents under their care and therefore are able to gather intelligence regarding ways to better support each individual, and to look for signs that could indicate an impending deterioration in wellbeing or behaviour. Staffing numbers within each AP are viewed to be on a level that restricts the ability for rehabilitative activities to take place, and many staff feel are potentially unsafe.

Chapter 6 - Recommendations

National recommendations

1. Local health boards should have an identifiable person whose role includes the provision of medical care for AP residents, possibly as part of a portfolio for the medical care of all groups accommodated at the will of the state. This would reflect the additional health needs of these groups and ensure the temporary nature of their accommodation does not act as a barrier to the provision of adequate care.
2. Local health boards should review their provision of community and secondary care mental health services in place and consider appointing a single point of contact for AP managers to approach in the event of the need for urgent assessment or treatment. This could include periodic clinics within the AP as deemed appropriate.
3. Local health boards should ensure that the movement of individuals at the will of the state between areas should not act as a barrier to the provision or continuation of appropriate care.
4. Local health boards and prison prescribers should conduct a review of the prescription of medication for those leaving prison and moving to an AP to ensure that gaps in medication availability are avoided. In cases where a gap in supply is likely, there should be a system in place for prison providers to send a prescription to a pharmacy local to the AP so that medication may be stored securely and dispensed as prescribed until a supply can be re-established. The review should include an assessment of which of the medications prescribed in prison GPs are willing to re-prescribe and which require the intervention of a specialist team.
5. Local health boards should review the provision of access to dental care for each AP. If capacity is not available locally from the general dental services, then provision should be considered within the salaried dental services.
6. Local health boards should consider ways to decrease the number of prisoners who restart smoking on release.
7. Local authorities should review the current provision of accommodation for residents on leaving the AP with the aim to have plans in place at an earlier stage to alleviate additional anxiety, and to ensure that residents are never released to being homeless. This review could include the ability for residents to be transferred to another local authority if being housed within their location of origin would make reoffending more likely.
8. HMPPS should conduct a review of the external services in place in each AP to service the health and social needs of the residents with a view to providing a blueprint to ensure the provision of a universal offer irrespective of location. This could include a collection of examples of best practice in each AP and work on a national basis with local health boards, local authorities, and other providers to ensure services are provided equally.
9. HMPPS should consider making the Partnership and Stakeholder Lead for Approved Premises into a substantive role.
10. HMPPS should review staffing levels in each AP to ensure adequate provision is in place to allow for rehabilitative activities to take place whilst simultaneously ensuring AP staff members' welfare is maintained. This review should include an assessment of the effects of having staff members on long-term sickness.
11. HMPPS should conduct a review of the ability of each AP to carry out organised activities. The review should include the availability of means of transportation, and consideration should be given to the availability of an amount of petty cash to be used at the discretion of AP managers or senior staff members.

12. HMPPS should regularly follow the journey of a sample of residents through the AP part of the criminal justice system, from initial contact with the AP until the resident is established within the community. This would allow early surveillance of aspects of the system which are working well, and which need more attention.
13. HMPPS should consider how AP staff could be included into the holistic management of each resident.

Local recommendations

14. Each AP should consider producing a welcome video which can be made available to any prospective resident to alleviate any undue anxiety, demonstrate the physical environment, and set out expectations. The video could be produced by current or former residents and feature staff members and its production could constitute purposeful activity. Sufficient resources and funding would be required from HMPPS to facilitate this.
15. APs should ensure that they are offering a range of health improvement interventions as part of their service including smoking cessation, the five ways to wellbeing, healthy eating, and physical activity.
16. APs should consider the use of former residents as peer mentors to ease the transition to living within the AP and to provide support in the provision of activities.

Evaluation

17. The function of APs in Wales should be evaluated regularly against metrics measuring health and social care indicators.

Chapter 6 – Summary

This Health and Social Care Needs Assessment aimed to explore the needs of residents in approved premises in Wales by the use of quantitative and qualitative research methods. The results show that, whilst physical health conditions are encountered at rates similar or below the rates experienced in the general population, mental health and neurodiverse conditions are overrepresented at rates of up to nine times the background level.

Unmet needs are mainly related to access to mental health services, in the maintenance of a continued supply of prescribed medications, access to dental care services, and in the provision of accommodation on release.

This HSCNA has provided a number of recommendations for individual APs, HMPPS, and the wider health and social care system for ways to better meet the needs of residents.

Further research into those on probation and within APs is required, and any changes implemented in response to these recommendations should be subject to continual evaluation to ensure a beneficial impact on this population.

References

Antunes, S. O., Wainwright, V. & Gredecki, N., 2021. Suicide prevention across the UK criminal justice system: an overview of current provision and future directions. *The Journal of Forensic Practice*, 23(1), pp. 53-62.

ASH, 2022. *Fact Sheet: Use of e-cigarettes (vapes) among adults in Great Britain,* s.l.: s.n.

BBC, 2022. [Online]
Available at: https://www.bbc.co.uk/news/health-62253893
[Accessed 13 08 2023].

BCUHB, 2021. *HMP Berwyn Health and Social Care Needs Assessment,* s.l.: s.n.

Birmingham, L., Mason, D. & Grubin , D., 1997. Health screening at first reception into prison. *Journal of Forensic Psychiatry*, 8(2), pp. 435-9.

BMA, 2020. *Autism Spectrum Disorder.* [Online]
Available at: https://www.bma.org.uk/what-we-do/population-health/improving-the-health-of-specific-groups/autism-spectrum-disorder

BMJ Best Practice, 2017. *Attention deficit hyperactivity disorder in adults.,* s.l.: BMJ Publishing Group.

British Heart Foundation, 2023. *UK Factsheet,* s.l.: s.n.

Brooker, C., Fox, C., Barrett, P. & Syson-Nibbs, L., 2015. *A health needs assessment of offenders on probation caseloads in Nottinghamshire and Derbyshire: report of a pilot study.,* s.l.: s.n.

Brooker, C. et al., 2012. Probation and mental illness. *The Journal of Forensic Psychiatry & Psychology*, 23(4), pp. 522-537.

Brooker, C., Syson-Nibbs, L., Barrett, P. & Fox, C., 2009. Community managed offenders' access to healthcare services: Report of a pilot study. *The Journal of Community and Criminal Justice*, 56(1), pp. 45-59.

Condon, L. et al., 2007. Users' views of prison health services: a qualitative study. *Journal of advanced nursing*.

Cooper, R., 2018. *A health needs assessment of offenders in the community,* s.l.: Derbyshire and Derby City.

Davies, K., 2018. *Addressing health inequalities within the criminal justice system.* [Online]
Available at: https://www.england.nhs.uk/blog/addressing-health-inequalities-within-the-criminal-justice-system/
[Accessed 17 11 2022].

Department of Health, 2009. *The Bradley Report - Lord Bradley's Review of people with mental health problems or learning disabilities in the criminal justice system,* London: Department of Health.

DHSC, 2022. *Care and support statutory guidance.* [Online]
Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[Accessed 25 10 2022].

Edgar, K. & Rickford, D., 2009. *Too Little Too Late: An Independent Review of Unmet Mental Health Need in Prison,* London: Prison Reform Trust.

Fazel, S., Bains, P. & Doll, H., 2006. Substance abuse and dependence in prisoners: a systematic review. *Addiction*, 101(2), pp. 181-191.

Gale, N. et al., 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, Volume 117.

Gale, N. K. et al., 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology,* 13(117).

Hayes, S., Shackell, P., Mottram, P. & Lancaster, R., 2007. The prevalence of intellectual disability in a major UK prison. *British Journal of Learning Disabilities*, pp. 162-167.

Health Development Agency, 2005. *Summary: health needs assessment at a glance,* s.l.: s.n.

Heidari, E., Dickinson, C., Wilson, R. & Fiske, J., 2007. Oral health of remand prisoners in HMP Brixton, London. *British Dental Journal*.

Heide, S. & Chan, T., 2018. Deaths in police custody. *Journal of Forensic and Legal Medicine*, Volume 57, pp. 109-114.

Herbert, K., Plugge, E., Foster, C. & Doll, H., 2012. Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review. *The Lancet*, 379(9830), pp. 1975-1982.

HM Inspectorate of Prisons (HMiP), 2009. *Disabled Prisoners: A Short Thematic Review on the Care and Support of Prisoners with a Disability,* London: HM Inspectorate of Prisons..

HM Inspectorate of Prisons (HMiP), 2010. *Alcohol Services in Prison: An Unmet Need,* London: HM Inspectorate of Prisons..

HM Inspectorate of Probation, 2017. *Probation Hostels' (Approved Premises) Contribution to Public Protection, Rehabilitation and Resettlement: An inspection by HM Inspectorate of Probation,* s.l.: s.n.

HMPPS, 2021. *The Target Operating Model for probation serives in England and Wales: Probation Reform Programme,* s.l.: s.n.

Kroll, L. et al., 2002. Mental health needs of boys in secure care for serious or persistent offending: a prospective, longitudinal study.. *Lancey*, pp. 1975-79.

MacMillan, 2023. *Cancer prevalence.* [Online]
Available at: https://www.macmillan.org.uk/about-us/what-we-do/research/cancer-prevalence#:~:text=There%20are%203%20million%20people,and%204%20million%20by%202030.
[Accessed 13 06 2023].

Mazzilli, S., 2019. *Prison As a Social Determinant of Health.* [Online]
Available at: https://www.isglobal.org/en/healthisglobal/-/custom-blog-portlet/prison-as-a-social-determinant-of-health/5083982/10102
[Accessed 16 11 2022].

Ministry of Justice, 2022. *Offender Management Statistics Bulletin, England and Wales,* London: Ministry of Justice.

Ministry of Justice, 2023. *Justice data.* [Online]
Available at: https://data.justice.gov.uk/
[Accessed 26 06 2023].

Moran, P., Rooney, K., Tyrer, P. & Coid, J., 2014. *Adult Psychiatric Morbidity Survey 2014, Chapter 7,* s.l.: s.n.

Murphy, G. et al., 2017. Offenders with intellectual disabilities in prison: what happens when they leave?. *Journal of Intellectual Disability Research*, 61(10), pp. 957-968.

National Probation Service, 2019. *National Probation Service Health and Social Care Strategy 2019-2022,* s.l.: s.n.

Newbury-Birch, D., Harrison, B., Brown, N. & Kaner, E., 2009. Sloshed and sentences: A prevalence study of alcohol use disorders among offenders in the North East of England. *International Journal of Prisoner Health*, 5(4), pp. 201-211.

NHS, 2022. *Dyslexia - Overview.* [Online]
Available at:
https://www.nhs.uk/conditions/dyslexia/#:~:text=It%27s%20estimated%20up%20to%201,successful%20at%20school%20and%20work.

NHSinform, 2023. *Arthritis.* [Online]
Available at: https://www.nhsinform.scot/illnesses-and-conditions/muscle-bone-and-joints/conditions/arthritis
[Accessed 13 06 2023].

NICE, 2022. *What is the prevalence of asthma?.* [Online]
Available at: https://cks.nice.org.uk/topics/asthma/background-information/prevalence/#:~:text=Asthma%20affects%20more%20than%20300,have%20been%20diagnosed%20with%20asthma.
[Accessed 12 06 2023].

Offender Management Act, 2007. [Online]
Available at: https://www.legislation.gov.uk/ukpga/2007/21/section/13
[Accessed 25 10 2022].

ONS, 2023. *Census 2021.* [Online]
Available at:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021#:~:text=In%20England%2C%20in%202021%2C%20a,(23.4%25%2C%20696%2C000).
[Accessed 13 06 2023].

ONS, 2023. *Risk factors for undiagnosed high blood pressure in England: 2015 to 2019.* [Online]
Available at:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/riskfactorsforundiagnosedhighbloodpressureinengland/2015to2019#:~:text=In%202019%2C%20official%20statistics%20from,7%3A%20Data%20sources%20and%20quality.
[Accessed 12 06 2023].

Pari, A. et al., 2012. Health and wellbeing of offenders on probation in England: an exploratory study. *The Lancet*, 380(S21).

PHE, 2020. *Health and social care needs assessments of adults under probation service supervision in the community,* London: PHE.

Phillips, J., Padfield, N. & Gelsthorpe, L., 2018. Suicide and community justice. *Health & Justice*, Volume 14.

Phillips, J. & Roberts, R., 2019. *Deaths of people following release from prison,* London: INQUEST.

Pratt, D. et al., 2006. Suicide in recently released prisoners: a population-based cohort study. *The Lancet*, 368(9530), pp. 119-123.

Probation Service, 2022. *About Us.* [Online]
Available at: https://www.gov.uk/government/organisations/probation-service/about
[Accessed 23 11 2022].

Public Health England, 2016. *Learning Disabilities Observatory. People with learning disabilities in England 2015: Main Report,* s.l.: PHE.

Public Health England, 2016. *Psychosis Data Report,* s.l.: s.n.

Rayner, J., Kelly, T. & Graham, F., 2005. Mental health, personality and cognitive problems in persistent adolescent offenders require long-term solutions: a pilot study.. *J Forensic Psychiatry Psychol*, pp. 248-62.

Rebbapragada, N., Furtado, V. & Hawker-Bond, G. W., 2021. Prevalence of mental disorders in prisons in the UK: a systematic review and meta-analysis. *BJPsych Open*, 7(S1), pp. S283-S284.

Revolving Doors Agency, 2018. *Written evidence to House of Commons Health and Social Care Committee,* s.l.: s.n.

Ritter, C. et al., 2011. Smoking in prisons: the need for effective and acceptable interventions. *J Public Health Police*, 32(1), pp. 32-45.

RNIB, 2023. *Key information and statistics on sight loss in the UK.* [Online]
Available at: https://www.rnib.org.uk/professionals/health-social-care-education-professionals/knowledge-and-research-hub/key-information-and-statistics-on-sight-loss-in-the-uk/
[Accessed 13 06 2023].

RNID, 2023. *Prevalence of deafness and hearing loss.* [Online]
Available at: https://rnid.org.uk/about-us/research-and-policy/facts-and-figures/prevalence-of-deafness-and-hearing-loss/
[Accessed 13 06 2023].

Roberts, M., Hsiao, W., Berman, P. & Reich, M., 2008. *Getting Health Reform Right.* Oxford: Oxford University Press.

Rouxel, P., Duijster, D., Tsakos, G. & Watt, R., 2013. Oral health of female prisoners in HMP Holloway: implications for oral health promotion in UK prisons. *British Dental Journal*, pp. 627-632.

Semenza, D. C. & Grosholz, J. M., 2019. Mental and physical health in prison: how co-occurring conditions influence inmate conduct. *Health and Justice*, 7(1).

Singleton, N. et al., 2003. Psychiatric morbidity among adults living in private households. *International Review of Psychiatry*, 15(1-2), pp. 65-73.

Singleton, N., Gatward, R. & Meltzer, H., 1998. *Psychiatric morbidity among prisoners in England and Wales.* s.l.:s.n.

Snell, N. et al., 2016. S32 Epidemiology of chronic obstructive pulmonary disease (COPD) in the uk: findings from the british lung foundation's 'respiratory health of the nation' project. *Thorax*, A20 71, 71(A20).

Sturge, G., 2022. *UK Prison Population Statistics,* London: House of Commons Library.

Tucker, S. et al., 2018. Social Care in Prison: Emerging Practice Arrangements Consequent upon the Introduction of the 2014 Care Act. *The British Journal of Social Work*, 48(6), pp. 1627-1644.

Welsh Government, 2020. *Healthy Weight Healthy Wales: renewed priorities for 2020 to 2021.* [Online]
Available at: https://www.gov.wales/healthy-weight-healthy-wales-renewed-priorities-2020-2021-html#:~:text=Information%20on%20the%20health%2Drelated,including%2025%25%20who%20are%20obese.
[Accessed 12 06 2023].

Whicher, C., O'Neill, S. & Holt, R., 2020. Diabetes in the UK: 2019. *Diabet Med,* 37(2), pp. 242-247.

Appendices

Appendix 1 - Resident survey


Questionnaire%20-%20residents%20v1.1%20


Questionnaire%20-%20residents%20v1.1%

Appendix 2 – Focus Group information and consent form.

Focus%20group%20information%20sheet.

Focus_Group_consent.docx

Appendix 3 – Stakeholder survey

Stakeholder survey.pdf

Appendix 4 – Stakeholders

HMPPS

- AP team
- Reducing Reoffending Team
- Community Accommodation Services team
- Public Protection Team

His Majesty's Inspectorate of Probation

Police

- North Wales Police
- South Wales Police
- Dyfed-Powys Police
- Gwent Police

Healthcare providers

- Betsi Cadwaladr University Health Board
- Cardiff and Vale Health Board
- Swansea Bay Health Board

Local Authorities

- Wrexham County Borough Council
- Gwynedd Council
- Cardiff Council
- Swansea Council

Other providers of services for APs

- Dechrau Newydd
- Department of Work and Pensions
- Prison and AP Chaplaincy services
- Dyfodol
- The Disabilities Trust
- Kaleidoscope
- Adferiad
- Small Woods Project

Third sector organisations working with people on probation

- Nacro
- Unlock
- Wales Safer Communities Network

Other

- Swansea Bay Regional Partnership Board
- North Wales Regional Partnership Board
- Cardiff and Vale Regional Partnership Board
- MAPPA Gwent
- MAPPA Dyfed Powys
- MAPPA North
- MAPPA South
- Public Health Wales Health and Justice Team
- Welsh Government
- Family Connect
- Members of the North Wales Families Affected by Imprisonment (FABI) Programme
- Prison Advice and Care Trust
- Shelter Cymru
- Clinks
- Pobl Group